❑ NEW PATIENT
❑ UPDATE / CHANGE

If your visit today is for an accident or a work injury check with the Receptionist before completing this form

William P. Maier, MD, PC
(541) 434-5585 • FAX (541) 345-2821

ACCT. NO. ______

PATIENT INFORMATION

SOCIAL SECURITY # / /	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (JR., SR., MD.)

SEX ❑ M ❑ F | BIRTH DATE / / | MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ LEGALLY SEPARATED ❑ OTHER

ADDRESS | CITY | STATE | ZIP

EMPLOYMENT STATUS
❑ EMPLOYED ❑ SELF EMPLOYED ❑ NOT EMPLOYED ❑ DISABLED ❑ RETIRED ❑ HOMEMAKER ❑ FULL TIME STUDENT ❑ PART TIME STUDENT ❑ CHILD

EMPLOYER | JOB TITLE

ADDRESS | CITY | STATE | ZIP

HOME TELEPHONE | WORK TELEPHONE | CELL PHONE | E-MAIL

DRIVERS LICENSE # | STATE | REFERRED BY | PCP

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME | TELEPHONE #

ADDRESS | SUBSCRIBER'S EMPLOYER

EFFECTIVE DATE FROM / / END TO / / | GROUP # | SUBSCRIBER/POLICY #

POLICY HOLDER/SUBSCRIBER | LAST NAME | FIRST NAME | M.I. | SUBSCRIBERS BIRTH DATE / /

SUBSCRIBER ADDRESS (IF DIFFERENT THAN PATIENT) | CITY | STATE | ZIP

RELATIONSHIP OF PATIENT TO SUBSCRIBER
❑ SPOUSE ❑ CHILD ❑ SELF ❑ OTHER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME | TELEPHONE #

ADDRESS | SUBSCRIBER'S EMPLOYER

EFFECTIVE DATE FROM / / END TO / / | GROUP # | SUBSCRIBER/POLICY #

POLICY HOLDER/SUBSCRIBER | LAST NAME | FIRST NAME | M.I. | SUBSCRIBERS BIRTH DATE / /

SUBSCRIBER ADDRESS (IF DIFFERENT THAN PATIENT) | CITY | STATE | ZIP

RELATIONSHIP OF PATIENT TO SUBSCRIBER
❑ SPOUSE ❑ CHILD ❑ SELF ❑ OTHER

EMERGENCY CONTACT

LAST NAME | FIRST NAME | MIDDLE NAME | HOME TELEPHONE

ADDRESS | CITY | STATE | ZIP

RELATIONSHIP TO THE PATIENT

EMPLOYER | WORK TELEPHONE (IF KNOWN)

AUTHORIZATION FOR TREATMENT FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize William P. Maier, M.D., P.C. to provide my insurance companies all information necessary to process insurance claims and assign to William P. Maier, M.D., P.C. all of the insurance benefits due to me to the full extent of my financial obligations. A photocopy of this authorization shall be considered as valid as the original.

PATIENT OR GUARDIAN SIGNATURE ______ DATE ______

WITNESS ______ DATE ______