PATIENT REGISTRATION
Wilson Medical Group

Kerrie-Anne Heron MD, David Kiragu MD,
David Propst, PA-C, Brittany Marshburn PA-C

DATE: _____ FEMALE: _____ MALE: _____

NAME: Last_____ First _____Middle Initial ___

ADDRESS: _____\

PHONE: Primary _____ Other _____ Work _____

EMAIL: _____ Web Enable for Patient Portal ☐ YES or ☐ NO

DATE OF BIRTH: _____Age: _____ SS #_____

LANGUAGE: _____ RACE: _____ ETHNICITY:_____

_____Married _____Single _____Widowed _____Divorced _____Separated _____Student

PHARMACY INFORMATION: Name_____ Phone_____

PHARMACY ADDRESS: _____

EMPLOYER INFORMATION: Name_____ Phone_____

EMPLOYER ADDRESS: _____

OCCUPATION: _____ _____Full time _____Part time

EMERGENCY CONTACT: Name_____

EMERGENCY CONTACT: Phone_____ Relationship_____

INSURANCE COMPANY: Primary_____ Policy Holder's Name____

INDENTIFICATION #_____ GROUP #_____

INSURANCE COMPANY: Secondary_____ Policy Holder's Name_____

INDENTIFICATION #_____ GROUP #_____

SPOUSE NAME: _____SPOUSE DATE OF BIRTH_____

SPOUISE SS#_____SPOUSE EMPLOYER_____

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:
I request that payment of authorized Medicare benefits and/or other health insurance be made on my behalf to Wilson Medical Group, PLLC, for services rendered to me by the physician. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services or any health insurance company and its agents any information needed to determine these benefits payable for related services.

DATE: _____ SIGNED:_____