WILLIAM E. WOODS, M.D., S.C.
PATIENT INFORMATION SHEET

Name _____
Last **First** **MI**

Address _____ **Apt.**_____
Street **City** **State** **Zip code**

Email address: _____

Best Contact # ( ) _____ **Alternate # ( ) _____**
(Home/Cell/Work - please circle one) **(Home/Cell/Work - please circle one)**

Date of Birth _____ **Soc. Sec #** _____

Please complete the following:

RACE: _____ **ETHNICITY:** _____ **LANGUAGE:** _____

Marital Status: Single Married Widowed Divorced Separated Other _____ **(Please circle one)**

REFERRED BY? _____ ***** **Primary Care Physician name** _____

Patient Employer _____

Address _____**Telephone# ( )**_____

Patient Occupation _____

Insurance Policyholder's Name _____

Policyholder Soc. Sec # _____ **Policyholder's DOB** _____

EMERGENCY CONTACT:

Name _____ **Relationship** _____ **Phone** _____

PHARMACY INFORMATION

Pharmacy name:_____ **Telephone #** _____

Address or intersection: _____

Mail order pharmacy name: _____

MEDICAL WAIVER:

If you are not available at the time we try to call you, may we leave medical information on your answering machine or voicemail? ____ Yes ____ No

PERMISSIONS

I give permission for _____who is my _____ to obtain information
(Name) **(relationship to you)**
results and any inquires regarding my health information, appointments and billing information. Their telephone number is _____.

Updated by: _____
Patient Signature (Under 18, needs to be signed by guardian) **Date**