

1001 South Douglas Hwy Suite B

Gillette, WY 82716

Phone 307-682-7500 Fax 307-682-7585

**Demographic Information**

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MI**\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State**\_\_\_\_\_\_**Zip**\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

**Home Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SSN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Martial Status** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Race** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Language**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity \_\_\_\_\_\_Hispanic or Latino \_\_\_\_\_\_\_\_Not Hispanic or Latino Advance Directive \_\_\_\_Yes\_\_\_\_ No**

**Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Preference**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employers Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Referring Physician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guarantor Information**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Insurance ID**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance ID**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SubscriberName**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Workers Comp ID**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Injury**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records Release Authorization**

**I authorize and direct any holder of medical information regarding my medical history, symptoms, treatment, examination results or diagnosis to release ALL information to Kris A Canfield MD. I also give my permission for records FROM any physician, hospital or any other medical provider to release BY Kris A Canfield MD as pertains to their care of me. This authorization shall remain in full force and effect until revoked in writing by myself. A photocopy of this authorization shall be considered as valid as the original.**

**Insurance Authorization and Assignment**

**I authorize Kris A Canfield, MD to release any information needed to my insurance carriers to determine benefits payable for related services. I herby assign to Kris A Canfield, MD all payments for medical/surgical services rendered to me and or my dependents.**

**In consideration of professional services rendered to the above patient, I/we agree to pay your customary charge for these services in full at the time of service, unless other arrangements are made with the Doctor or office manager. I/we authorize the Doctor to receive assignment of Insurance payments. If the customary charges are more that the benefits allowed under any Insurance plan that I/we have, I/we agree to pay the difference.**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient or Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**