

Thank You For Selecting Dr. Wells and His Staff!

To help us meet all your healthcare needs, please fill out this form completely.
If you have any questions or need assistance, please ask and we will be happy to help.

Patient Information (confidential)

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Phone _____

If student, Name of School/College _____ Full Time/Part Time _____

Patient's or Parents Employer _____ Work Phone _____

Spouse or Parents Name _____ Employer _____ Work Phone _____

Whom May We Thank For Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____ Birthdate _____

Employer _____ Wk. Phone _____ Soc. Sec. # _____

For your convenience, we offer the following methods of payment: Cash, check, Visa, MasterCard, Discover, and American Express.
Payment is requested in full at each appointment. Please let us know if you would like information on our office's payment arrangements.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec. # _____ Home Phone _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group No. _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature of Patient (Parent if Minor)

Date