Reed I Ward D O
Family Medicine Physician

3425 Potomac Way
Idaho Falls, ID 83404
Office: (208) 528-8170

Patient Information

Last Name_____ First Name _____ MI _____M / F

Home Address_____ City_____ State_____ Zip_____

Social Security No. _____ Home #_____ Work #_____

Age _____ Birthdate_____ Single_____ Married_____ Divorced_____ Widow_____

Employer_____ Occupation_____

Spouse's Name_____ Birthdate_____ SS#_____

Spouse's Employer_____ Occupation_____

Nearest Relative_____ Relationship_____ Phone_____

Allergies to Medicines_____ Referred by_____

Billing Information

Guardian or person responsible for payment (if different from above)_____

Address_____ City_____ State_____ Zip_____

Phone No._____ SSN#_____Relationship to patient_____

Employer_____ Work #_____ Birthdate_____

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Co. _____	Insurance Co._____
Policy No._____	Policy No._____
Group No._____	Group No._____

Medical Records Release Information

I authorize and direct any holder of medical information regarding my medical history, symptoms, treatment, examination results or diagnosis to release such information to another medical provider and/or medical facility. I also give my permission for records from any physician, hospital, or any other medical provider be released to REED I. WARD, D.O., PA, as pertains to his 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 REED I. WARD, D.O., PA, to release any information needed to my insurance carriers to determine benefits payable for related services. I hereby assign to REED I. WARD, D.O., PA, all payments for medical services rendered to myself and/or my dependents.

1/We understand that my medical insurance company may not pay for all of the services provided because the service may not be a covered benefit. If this is the case, I/We will be responsible for paying this service. I also understand that I am responsible for payment regardless of insurance coverage.

By signing below I/We acknowledge that I/We wish to have services performed & agree to be responsible for paying the cost of the service if the insurance company does not cover the service. I/We agree to pay for these services in full at the time of service, unless other prior arrangements have been made.

Signature_____ Date_____