DRS. GOTT, GOLDRATH, TROY AND WU, S.C.

Laurence Gott, M.D. Richard B. Troy, M.D. David E. Goldrath, M.D. Ning Z. Wu, M.D.

PATIENT INFORMATION (Please Print) ☐ Male ☐ Female Date ____________________

Patient ___________________________________ Birth Date ______________ Social Security No.____________________

Address ____

City ______________________________________ State _______ Zip ____________ Name of Spouse __________________

Home Phone (____) ________________________ Work Phone (____) ________________________ Extension __________

IN CASE OF EMERGENCY OR INABILITY TO REACH PATIENT PLEASE CALL:

Name ___________________________________Phone (____) ___________________ Relationship __________________

PLEASE CHECK CORRECT BOX:

EMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT ☐

Employer's Name OR School Name ____ Phone (____) ________________

Address ______________________________ City _________________________________ State ______ Zip ______________

PRIMARY INSURANCE PLAN NAME: ____

Insured's Group Policy Number __________________________ Insured's ID Number __________________________________

Insured if other than patient ____ Birth Date ______________________

Insured Person's Employer ____ Phone (____) ___________________

Please indicate if appropriate ☐ HMO ☐ PPO

IS THERE ANOTHER HEALTH PLAN – INS. CO. NAME: ____

Insured's Group Policy Number __________________________ Insured's ID Number __________________________________

Insurance Co. Address ____________________________ City _______________________ State ______ Zip ______________

Insured's Name _________________________________ Birth Date ___________________ Employer ____________________

Employer's Address ______________________________ City _______________________ State ______ Zip ______________

Insured's Relationship to Patient ☐ Spouse ☐ Patient ☐ Other: ____

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.

SIGNED ____ DATE ____________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits direct to DRS. GOTT, GOLDRATH, TROY and WU, S.C. for medical/surgical services rendered to me or my dependents.

SIGNED ____ DATE ____________________________

Please complete all information and attach a copy of your insurance card to this form so that the receptionist may copy it for the file.