



MORELAND FAMILY MEDICINE ASSOCIATES, S.C.

717 W. Moreland Boulevard, Waukesha, Wisconsin 53188

PATIENT INFORMATION

Name of Patient _____

Maiden Name if applicable _____

Address _____

City _____ State _____ Zip _____

Patient Phone # _____

Social Security # _____

Sex M F Date of Birth _____

Marital Status

Single Married Divorced Widow

MFMA Doctor _____

Employer _____

Address _____

City _____ State _____ Zip _____

Employer Phone # _____

RESPONSIBLE PARTY INFORMATION (If Different Than Above)

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____

SS# _____

Employer _____

Address _____

City _____ State _____ Zip _____

Employer Phone # _____

EMERGENCY CONTACT

Name _____

Phone _____

Work Phone _____

INSURANCE

Please present current insurance card. Patients will be billed for all services if insurance information is not available.

MEDICAL CONSENT; I, the undersigned, hereby consent to medical care including, but not limited to examinations, laboratory procedures, X-rays, medical or surgical treatments and the administration of medications, as are, in the judgment of the treating practitioner, medically advisable or appropriate for the patient identified below. I understand that no guarantee has been made as to the result of the care, treatment and medications of the patient.

PATIENT AUTHORIZATION STATEMENT

I, the undersigned, authorize Moreland Family Medicine Associates, S.C., to release all needed information to my insurance company, I also authorize my insurance company to pay all benefits to Moreland Family Medicine Associates, S.C.

Patient Signature

Date

Signature of Authorized Person

Date