Reset Form

wellspire
inspiring better health

Date: _____

Name of person completing form (if not the patient) and your relationship:
Who can we thank for referring you to our practice?
Have you seen one of our physician's before? If so, whom and when?

Patient Information

Last Name	
First Name	
Middle Initial	
Sex	Male ◯ Female ◯
Marital Status	Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed ◯
Date of Brith	
Social Security #	
Driver's License #	
Email (by providing an address, you authorize us to communicate with you in this manner)	
Street Address 1	
Street Address 2	
City, State, & Zip	

Employer

Do you have an Advanced Directive?	
Employer Name	
Work Address	
Can We Call You At Work?	

Phone Numbers Check Preferred in Column 3		
Home		◯
Mobile/ Cell		◯
Work		◯
Other		◯

Race (check one)	
White	◯
Hispanic	◯
Black/African American	◯
Asian	◯
American Indian/Alaska Native	◯
Hawaii Native	◯
Other Pacific Islander	◯
More than 1 race	◯
Decline	◯

Preferred Language (check one)	
English	◯
Spanish	◯
Hindi	◯
Russian	◯
Other	◯

Responsible Party

Last Name	
First Name	
Middle Initial	
Street Address	
City, State & Zip	
Relationship To Patient	

wellspire
inspiring better health

Patient Name: _____

Insurance

Primary Insurance (Mandatory Unless Self Pay)	
Insurance Co. Name	
Insured's Last Name	
Insured's First Name	
Insured's Date of Birth	
Insured's SSI #	
Policy #	
Group #	
Relation To Patient	
Insured's Employer	

Secondary Insurance (Initial here if you DO NOT HAVE secondary insurance _____)	
Insurance Co. Name	
Insured's Last Name	
Insured's First Name	
Insured's Date of Birth	
Insured's SSI #	
Policy #	
Group #	
Relation To Patient	
Insured's Employer	

We Do Not File Past Secondary Insurance

Emergency Contact

Emergency Contact #1	
Name	
Phone Number	
Relationship To You	
Sign below if you authorize this person to receive your Private Health Information	

Emergency Contact #2	
Name	
Phone Number	
Relationship To You	
Sign below if you authorize this person to receive your Private Health Information	

Pharmacy

Pharmacy Name	
Pharmacy Address	
Pharmacy Phone Number	

Medication Refill Policy:

Refills for medications prescribed by your doctor should be requested during your office visit. Requests by phone will be addressed at our earliest convenience. We encourage the use of our Patient Portal for these requests. Refills will not be approved after normal business hours, weekends or holidays. Therefore, please call in your refill request in a timely manner to us directly or for the pharmacy to contact our office.

Refills for controlled substances require an office visit. No exceptions will be made.

WE RESERVE AT LEAST 24 HOURS TO PROCESS ALL REFILL REQUESTS

Initial here to acknowledge our medication refill policy: _____

Privacy

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that the notice of Privacy Practices was available and that I have read (or had the opportunity to read) and understand the notice.

Signature of Patient or Authorized Representative _____