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Dr. James C. Walker, M.D.

Patient Information Form

OFFICE USE ONLY

Dr. James C. Walker**, M.D.**

Date ____________________________

Patient Information Section (Please fill out *every single* line)

Name ____ Age ________ Date of Birth __________________ Race _________________
Last First Middle

Sex: ☐ male ☐ female Social Security # ____________________________ Drivers License # /State ______________________________________

Mailing Address ____ APT# _________ City / State / Zip_____________________________

Email ____Marital Status:_____________________________

Phone: Home # _____________________ Work # _____________________ other # _____________________ Employer ___________________________

Language:____________________________________ Ethnicity (please check one): ☐ Hispanic ☐Non-Hispanic ☐ Refused to Respond

Preferred Pharmacy Name: ___________________________________Pharm Phone #: _____________________ City/State:_________________________

Emergency Contact? (someone outside of the home) _____________________________ Phone # ___________________ Relationship _________________

RESPONSIBLE PERSON INFORMATION: ☐ Spouse | ☐ Mother | ☐ Father | ☐ Guardian

Name __________________________________ Social Security # ____________________ DOB ____________ Employer _____________________________

Address ____ Phone: work # ____________________ other # _______________________

PATIENT INSURANCE INFORMATION

Insured Party __________________________________ Employer __________________________________ Social Security# ________________________
(Name on Insurance Card)

Insured Party DOB:______________________ Relationship to Patient____

I hereby instruct and direct ____ Insurance Company to pay by check made out and mailed to:

Dr. James C. Walker, M.D

Or if my current policy prohibits direct payment to my doctor and/or the service provider, I hereby also instruct and direct you to make the check to me and mail it as follows:

Dr. James C. Walker, M.D.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on this form. I authorize my doctor and/or the service provider to initiate a compliant to the Insurance Commissioner for any reason on my behalf.

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

X____ _________________________

Signature of Patient or Legal Representative Date