

# Peter V. Wilson, M.D.

1580 West Antelope Drive, Suite 230

Layton, UT 84041

(801) 728-9555

## Patient Information

(Last)	(First)	(Middle)	(Maiden)	
Name: _____				Date: _____
Address: _____		City: _____	State: _____	Zip: _____
Home Phone#: _____	Cell Phone#: _____	Work Phone #: _____		
Date of Birth: ____ / ____ / ____	Social Security #: _____	Marital Status:    Single   Married   Divorced   Widowed		
Primary Care Physician: _____		Referring Physician: _____		
Patient's Employer: _____		Occupation: _____		
Patient's Spouse Name: _____		Spouse Employer: _____		
Nearest Relative /Friend Not Living With You: _____				
Relation: _____		Phone #: (    ) _____		

## Policy Holder's Information If Other Than The Patient

(Last)	(First)	(M.)	
Spouse/Parent Name: _____		Relation: _____	
Address: _____		City: _____	State: _____ Zip: _____
Date of Birth: ____ / ____ / ____	Social Security #: _____		
Home Phone#: _____	Work Phone #: (    ) _____		
Employer Name: _____			

## Primary Insurance Information

Primary Insurance Company: _____			
Address: _____		City: _____	State: _____ Zip: _____
Insurance Phone #: _____			
Group #: _____			
Policy #: _____			
Copayment Amount: \$ _____	Policy Holder: _____		

## Secondary Insurance Information (if applicable)

Secondary Insurance Company: _____			
Address: _____		City: _____	State: _____ Zip: _____
Insurance Phone #: _____			
Group #: _____			
Policy #: _____			
Copayment Amount: \$ _____	Policy Holder: _____		

## Assignment and Release

I, the undersigned, have insurance coverage with the above listed insurance companies and assign Dr. Peter Wilson all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including the copay, deductible, coinsurance, and any other balances not paid by my insurance company. In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature (If under 18, legal guardian): \_\_\_\_\_ Date: \_\_\_\_\_