Tulsa Health Group
Steve Wiseman, M.D.

PATIENT INFORMATION

Primary Care Physician	Patient Name(Last, First, Middle)	Social Security Number

Date of Birth	Sex	Marital Status	Relationship to guarantor(if other than self, please fill out guarantor information)	Previous Name(if changed since last visit)
	☐ M ☐ F	☐ Single ☐ Widowed ☐ Married ☐ Divorced		

Address	City, State, Zip Code

Home Telephone ( )	E-mail (Optional)	Fax (Optional)

Employer	Work Telephone ( )	Pager/Cell Phone

Address	City, State, Zip Code

GUARANTOR INFORMATION, if patient is a minor

Responsible party or custodial parent	Guarantor Name(Last, First, Middle)	Social Security Number

Date of Birth	Sex	Relationship of patient to guarantor	Home Telephone ( )
	☐ M ☐ F		

Address	City, State, Zip Code

Employer	Work Telephone ( )

Address	City, State, Zip Code

EMERGENCY CONTACT

Contact Name (Person not living with you)	Relationship

Home Telephone ( )	Work Telephone ( )

SPOUSE OR OTHER PARENT (If applicable)

Name (Last, First, Middle)	Home Telephone ( )

Address (If different than patient)	City, State, Zip Code

Employer	Work Telephone ( )

INSURANCE

Primary Insurance Company Name	Telephone ( )

Address	City, State, Zip Code

Group Number	Certificate/Policy Number	Effective Date	Relationship to Subscriber (insured)

Subscriber's Name	Subscriber's Employer

Secondary Insurance Company Name	Telephone ( )

Address	City, State, Zip Code

Group Number	Certificate/Policy Number	Effective Date	Relationship to Subscriber (Insured)

Subscriber's Name	Subscriber's Employer

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Tulsa Health Group on my behalf for any unpaid services rendered by Tulsa Health Group physicians.

Signature	Date

I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits.

Signature	Date