

Please allow us to photocopy your insurance card(s)

INSURANCE INFORMATION:

Payment for services rendered is to be made as follows:

"I request that payment of authorized insurance benefits be made to RICHARD W. WAGUESPACK, M.D., PC, for any services or items furnished to me by the physician or supplier. I authorize the practice to release to the Health Care Financing Administration (HCFA/CMMS), my Insurance Carrier, and/or its agents appropriate information needed to determine these benefits or the benefits payable for related services, in accordance with HIPAA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductibles, copayments, and non-covered items (which have been explained to me from information supplied by my carrier). If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs of collection including the court costs and reasonable attorney fees."

Signature of Beneficiary or Person Signing for Beneficiary

Date Signed

Street Address, City, State, ZIP of Person Signing for Beneficiary

Relationship

Reason beneficiary is unable to sign _____

DISSEMINATION OF MEDICAL INFORMATION:

To whom may we, as your health care providers, release information about your medical condition(s)?

Relationship

Relationship

Relationship

Signature of Patient or Responsible Party

Date Signed

I, the undersigned, or as the parent or legal guardian of the undersigned authorize Dr. Richard Waguespack to render medical treatment to myself or the patient above for whom I am responsible.

Signature: _____ Date: _____

I, the undersigned, confirm that I have read the privacy policy of Dr. Richard Waguespack dated _____, which is posted in the waiting room.

Signature: _____ Date: _____

Richard W. Waguespack, MD

GENERAL MEDICAL CONCERNS Patient's name: _____

Date: _____

Please print form and answer the following questions:

Cardiovascular (heart, arteries, veins)

Hypertension Yes No
Heart murmur Yes No
Heart attack Yes No
Valve problems Yes No
Varicose veins Yes No
Stroke Yes No
Other: _____

Respiratory (lungs)

Asthma Yes No
Emphysema Yes No
Tuberculosis Yes No
Other: _____

Eye

Cataracts Yes No
Glaucoma Yes No
Other: _____

Genitourinary (kidney, bladder)

Kidney stones Yes No
Urinary tract infection Yes No
Other: _____

Men only

Enlarged prostate Yes No

Women only

Fibroid tumor Yes No
Pelvic Inflammatory Disease Yes No

Endocrine (hormones)

Diabetes Yes No
Other: _____

Gastrointestinal (stomach, liver, gallbladder & intestines)

Ulcer Yes No
Colitis Yes No
Gallstones Yes No
Reflux/heartburn Yes No
Cirrhosis/Liver Yes No
Hepatitis Yes No
Other: _____

Neurological (brain & nerves)

Migraines Yes No
Epilepsy Yes No
Sleep problems Yes No
Other: _____

Psychiatry

Neurosis Yes No
Depression Yes No
Schizophrenia Yes No
Other: _____

Hematologic (blood, cancer)

Bleeding problem Yes No
Cancer Yes No
If yes, where: _____
Other: _____

Musculoskeletal (muscles & bones)

Arthritis Yes No
Back problem Yes No
Hip/knee replacement Yes No
Bone fractures Yes No
Other: _____

Other

HIV or AIDS Yes No
Obesity Yes No
Alcoholism Yes No
Drug abuse Yes No

Completed by _____

Relationship to patient _____

Reviewed by: _____ MD