Washington Internists Group, L.L.C. (W.I.G.)

1140 19th Street NW, Ste 805 Washington D.C. 20036
Telephone (202) 728-9630 Fax (202) 222-0246 or (202) 296-0528

Date ____/____/_____ Date of Birth _____/_____/_____

Patient _____
First Name Middle Initial Last Name

Street Address _____

City _____ State_____ Zip _____

Home Phone ( ) _____ Work ( )_____ Cell ( )_____

Email Address _____

Which number can we leave a message concerning medical information on? Home____ Work ____ Cell ____

Sex: Male Female Transgender Social Security Number #: _____

Race: __ American Indian/Alaska Native __ Asian __Native Hawaiian or Other Pacific Islander __Caucasian
__Black or African American __Hispanic __ Other Race: _____

Marital Status (circle one): Single Engaged Married Partnered Separated Divorced Widowed

Reason for visit_____

Who should be notified in an emergency? _____ Phone _____
Relationship to you _____

Do you have medical insurance? ___Yes ___No Name of Insurance _____
Guarantor: _____ Relationship to you: _____
Secondary Insurance: _____

Place of Employment _____
Occupation _____

Do you have a regular pharmacy? If so, Name _____ Phone _____

How did you hear about us? _____

By signing below, I acknowledge that I have been provided a copy of the office policies and will abide by these policies. I acknowledge receipt of the Notice of Practices and consent to WIG's use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where WIG has already made disclosures based on my prior consent.

- Please provide us with your insurance cards at each visit.
- Please provide any changes in personal information (name changes, insurance changes, and address changes). Failure to provide updated information may affect your claim being processed correctly and efficiently.
- Only claims for services that have been paid in full will be submitted for reimbursement.
- Photo identification is also needed for insurance purposes. We are taking photographs of patients to attach to your electronic chart. Having your photograph attached to your chart helps ensure that we connect your face with your name which is very helpful to our staff and physicians.

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date