

ADA OUTPATIENT CLINIC

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Ada, OK 74820

Today's Date:	SSN:	DATE OF BIRTH:	Sex: Female Male
Patient's Name (First Middle Last)		Home Phone ()	Cell Phone: ()
Mailing Address		City and State	Zip Code
Employer	Occupation	Work Phone & Ext. ()	
Employer's Address		City and State	Zip Code
Spouse or Guarantor		Address, City, State	Zip Code
Spouse or Guarantor Date of Birth:	Spouse or Guarantor SS#	Spouse or Guarantors Employer and Address	
Primary Insurance	Primary Cardholder & Relationship	Group #	ID#
Policyholders Date of Birth:	Policyholders SSN:	Address if different from Guarantor:	
Secondary Insurance	Secondary Cardholder & Relationship	Group #	ID#
Policyholders Date of Birth:	Policyholders SSN:	Address if different from Guarantor:	
Injured on the job? Yes No	Injured in Motor Vehicle Accident? Yes No	If yes to either, date of injury:	
Name of Pharmacy	Emergency Contact Name & #: ()		

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of all information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to the practice. I understand that payment is due at the time of service and that I am financially responsible for all charges whether or not paid by the insurance.

X Name _____ Date _____