☐ CROSSROADS
21075 Swenson Dr.
Suite 600
Waukesha, WI 53186
(262) 798-8646
(262) 798-8640 FAX

☐ MORELAND MED.
1111 Delafield
Suite 208
Waukesha, WI 53188
(262) 542-2060
262) 542-0657 FAX

☐ DELAFIELD
2410 Milwaukee Street
Suite A
Delafield, WI 53018
(262) 646-4860
(262) 646-4869 FAX

Patient's Name: ______________________________ ____) ____________
Last First MI Home Phone

Home Address: ______________________________
Street City State Zip

Birth Date: ______________________________
MM/DD/YY Age Sex Marital Status S.S. No.

Patient's Employer: ______________________________ (____) ____________
Phone

Address: ______________________________
Street City State Zip

How were you referred to the clinic: ☐ Doctor ☐ Friend ☐ Ins. Co. ☐ Yellow Pages ☐ Other ____

COMPLETE IF PERSON RESPONSIBLE FOR BILLING OTHER THAN PATIENT

Policy Holder's Name:______________________ DOB: __________ SS#__________ __________
MM/DD/YY or Copy of Driver's License Relationship

Policy Holder's Address: ______________________________
Street City State Zip Phone

Policy Holder's Employer: ______________________________
Phone

Employer's Address: ______________________________
Street City State Zip

COMPLETE IF INJURY IS ACCIDENT RELATED

Injury related to: _____ W/C __________MVA __________Other Injury Date: __________

W/C or Auto Insurance: ______ Claim # : __________

Address: __________ __________

Adjuster: __________ Phone:__________ Are you Presently Working?

INSURANCE INFORMATION - PLEASE SHOW INSURANCE CARD TO RECEPTIONIST

First Insur. Name: ____________________ Policy Holder: ____________

Address: ______________________________
Street City State Zip

ID # ____________________ GPR#__________ Preauth _YES _NO

Second Insur. Name: __________ Policy Holder: ____________

Address: ______________________________
Street City State Zip

ID # ____________________ GPR#__________ Preauth _YES _NO

I REQUEST TREATMENT FOR MYSELF OR MINOR CHILD FROM WPTC & ASSIGN ALL MEDICAL BENEFITS TO WHICH OR MY DEPENDENTS ARE ENTITLED UNDER MY HEALTH INSURANCE.

____________________ ____________________ __________
SIGNATURE OF PATIENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE

(FOR OFFICE USE ONLY)

Referring Dr.: ____________________ Primary Dr.: ____________________ 1st RX __________

DX Code: ____________________ Description: ____________________ Eval PT: ______

Auth. # : ______________ # Visits: Dates: __________ Prev. Ther. Visits:

Medi POC: ______________________________ By: __________

Deduct/Co-pays/Coinsur: ______________________________