Patient Registration for Avery Wood MD

10 Bank Street   PO Box 726   North Bennington, Vermont 05257

Patient's Name: ____________________________   Date of Birth: _________________________

Mailing Address: ____

Marital Status: S M D W child   Gender: male female

Civil Union   Domestic Partner

Names of the People in Your Household: ____

____

Home Phone: _______________________________   Cell Phone: ___________________________

Email address:____

Emergency Contact Name: __________________________________Relationship:___________________

How to contact this person:____

Name of Employer:__________________________   Work Phone:___________________________

Address: ____

Job or Position:____

Name of Guarantor (the person who is responsible for this account): ______________________________

Date of Birth:__________________ Relationship:_____________________ Phone: __________________

Address: ____

Primary Insurance:______________________________   Certificate Number: ___________________

Group Number: _________________________________   Employer:_____________________________

Subscriber Name: ______________________________   Date of Birth___________________________

Secondary Insurance:_____________________________   Group Number: ________________________

Group Number: _________________________________   Employer:_____________________________

Subscriber Name: ______________________________   Date of Birth___________________________

Please check one:

☐ I will review the Policies and Procedure on Dr. Wood's website (www.averywoodmd.net) and return the signature page with this form or at the time of my first appointment.

or ☐ I need you to mail me a copy of Dr. Wood's Policies and Procedures. I will bring the signature page with me to my first appointment.

Patient's Name:____

Parent's or Guardian's Name (if other than self):____

Communication Authorizations

I authorize Avery Wood MD to leave messages on my phone's answering machine.

Signature:_____________________________ Date: ________________

I authorize Avery Wood MD to send me email at the address I provided on reverse.

Signature:_____________________________ Date: ________________

Insurance Benefits Agreement

I request that payment of authorized benefits be made on my behalf directly to Avery Wood MD for serviced furnished to me by that physician or her associates. I understand and agree that I am responsible for the balance of my accounts. I certify that the information I have provided is accurate to the best of my knowledge. I will notify this office of any changes.

Signature:_____________________________ Date: ________________

FOR MEDICARE BENIFICIARIES:

Medicare Beneficiary's Lifetime Payment Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Avery Wood MD, 10 Bank Street, North Bennington, Vermont, for any services furnished to me by Dr. Avery Wood. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature:_____________________________Policy Number:______________Date: ___________

Medigap (one time) Authorization Form

I request that payment of authorized Medigap benefits be made either to me or on my behalf to : Avery Wood MD, 10 Bank Street, North Bennington, Vermont, for any services furnished to me by Dr. Avery Wood. I authorize any holder of medical information to release to the following Medigap insurer: _____________________________ any information needed to determine these benefits payable for related services.

Signature:______________________________Policy Number:_____________ Date: ___________