Blairsville Internal Medicine

☐ *Mary Beth Wiles, MD* ☐ *Elizabeth Wiles, DO* ☐ *Jill Nielsen, DNP* ☐ *Suzanna Pollock, APRN*

Check Preferred Provider

LAST NAME _____ FIRST _____ MIDDLE _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

Preferred Call Number

HOME PHONE (_____)_____ [ ] RACE: ☐ White ☐ Asian ☐ Black ☐ Hawaiian

WORK PHONE (_____)_____ [ ] ☐ Indian ☐ Other ☐ Declined

CELL PHONE (_____)_____ [ ] ETHNICITY ☐ Hispanic ☐ Non-Hispanic

EMAIL _____ PREFERRED LANGUAGE _____

If your provider uses EMR, a care summary will be provided to you ☐ by Mail ☐ by Portal **(Requires registration. See Check In person.)**

SOCIAL SECURITY # _____ ☐ MALE ☐ FEMALE BIRTHDATE _____

EMPLOYER _____ ADDRESS _____

PHARMACY _____ LOCATION _____ PHONE (_____)_____

RESPONSIBLE PARTY ☐ Same as Patient ☐ Parent ☐ Legal Guardian ☐ Financial Power of Attorney

NAME _____ HOME PHONE (_____)_____

ADDRESS _____

SOCIAL SECURITY # _____ ☐ MALE ☐ FEMALE BIRTHDATE _____

EMPLOYER _____ WORK PHONE (_____)_____

EMPLOYER ADDRESS _____

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

NAME _____

SOCIAL SECURITY # _____ ☐ MALE ☐ FEMALE BIRTHDATE _____

EMPLOYER _____ WORK PHONE (_____)_____

EMERGENCY CONTACT ☐ CHECK IF SAME AS SPOUSE/PARTNER. IF NOT, PLEASE COMPLETE THE FOLLOWING:

NAME _____ RELATION TO PATIENT _____

HOME PHONE (_____)_____ WORK or CELL PHONE (_____)_____

PLEASE GIVE YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY.

1st INS _____ ID#_____ GRP _____

Billing Address _____ Billing Zip _____

2nd INS _____ ID#_____ GRP _____

Billing Address _____ Billing Zip _____

3rd INS _____ ID#_____ GRP _____

Billing Address _____ Billing Zip _____

Do you have a Living Will or Advance Directive? ☐ Yes Please provide a copy for your chart.

☐ Don't know ☐ No ☐ I want to discuss it with my provider.

Do you have an official Medical Power of Attorney? ☐ No ☐ Don't know ☐ Yes Please provide a copy for your chart.

If yes, name and phone: _____ (_____)_____

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References to "the practice(s)" in this document include Mary Beth Wiles, MD, PC; Mary Elizabeth Wiles, DO, PC; and Blairsville Internal Medicine and all its providers.

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