WIGHT CARE CLINIC REGISTRATION FORM
DAVID WIGHT, M.D.
7019 Rote Rd.
Suite 105
Rockford, Illinois 61107

Date _____

Patient Name _____
(Last) (First) (MI)

Address _____City _____ State _____ Zip _____

Home/Cell Phone _____Employer _____ Employer Phone _____

Date of Birth _____Age _____ Sex _____Social Security Number _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

*Emergency Contact Name _____ Emergency Contact Number _____

PRIMARY INSURANCE & CARD HOLDER (*If Different From Above*)

Name _____
(Last) (First) (MI)

Relationship to Patient _____Phone Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Employer & Phone _____

Name of Insurance Company_____ Phone Number _____

Subscriber ID Number _____ Group Number _____

SECONDARY INSURANCE & CARD HOLDER

Name _____
(Last) (First) (MI)

Relationship to Patient _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Employer & Phone _____

Name of Insurance Company_____ Phone Number _____

Subscriber ID Number _____ Group Number _____

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I hereby authorize release of information to file a claim with my insurance and assign benefits otherwise payable to me to be paid to the physician indicated on this form.
I authorize Wight Care Clinic and its agents to provide medical records to insurance companies as necessary.
I agree that any fee for service not covered by insurance will be paid at the time of service including copays and coinsurance.
I understand that I am financially responsible for any balance not covered by my insurance carrier.
I authorize transfer of all unpaid balances to my credit card after 120 days from the date of service. (A copy of this signature is as valid as the original).
I understand I will be charged for all collection fees, as well as for all fees incurred during the collection process.
I understand if my deductible has not been satisfied, my visit(s) will be an out of pocket expense.
Please include front and back copies of your Insurance Card (s).
NOTE: Appointments not cancelled 24 hours prior to appointment time will be charged per policy.

Signature (Patient or Guardian) _____Date _____