Robert L Whitson, D.O. & Dixie Bone, ARNP
846 Stevens Drive Richland, WA 99352 (509) 946-5233

PATIENT INFORMATION

Patient Account # ________ **(office will fill in)**

PLEASE PRINT

Patients Name ____________________
Address ____________________ (City) __________ (Zip) __________
Home Phone __________ Birthdate __________ Soc Sec # __________
Sex: _____(M) _____(F) Marital Status: (M) Married (S) Single (W) Widowed (D) Divorced (O) Other
Employer ____________________ Employer Address ____________________
Occupation ____________________ Employer Phone ____________________
Employment Status (F) Full Time (P) Part Time (R) Retired (N) Not Employed
Student Status (F) Full Time (P) Part Time (N) Not

DRUG ALLERGIES ____________________ | Pharmacy ____________________

SPOUSE OR LEGAL GUARDIAN OF PATIENT

Name ____________________ Sex __________(M) __________(F)
Address ____________________ (City) __________ (State) __________ (Zip) __________
Home Phone __________ Birthdate __________ Soc Sec # __________
Employer ____________________ Employer Address ____________________
Occupation ____________________ Employer Phone ____________________

PRIMARY INSURANCE

Insurance Co. ____________________
Insurance Address ____________________
Subscriber ____________________
Subscriber Address ____________________
Home Phone ____________________
Relationship to Patient ____________________
Subscriber Date of Birth ____________________
Subscriber Sex __________(M) __________(F)
Subscriber Soc Sec # ____________________
Group # ____________________
Subscriber Employer ____________________
Employer Address ____________________
Employer Phone ____________________
Marital Status (M)Married (S)Single (O)Other

SECONDARY INSURANCE

Insurance Co. ____________________
Insurance Address ____________________
Subscriber ____________________
Subscriber Address ____________________
Home Phone ____________________
Relationship to Patient ____________________
Subscriber Date of Birth ____________________
Subscriber Sex __________(M) __________(F)
Subscriber Soc Sec # ____________________
Group # ____________________
Subscriber Employer ____________________
Employer Address ____________________
Employer Phone ____________________
Marital Status (M)Married (S)Single (O)Other

Person to notify in case of emergency(someone not living with you)

Name ____________________ Relationship to patient ____________________
Address ____________________
Home Phone ____________________ Work Phone ____________________

Insurance Billing: I hereby authorize the doctor to furnish my insurance company all information which the insurance company may request concerning my present illness or injury. I hereby assign to the doctor all money to which I am entitled for office visits and/or surgical expense relative to the service reported. I understand that I am legally responsible to the doctor for charges not covered by the assignment.

DATE ____________________ Signature ____________________

I hereby authorize any medical treatment in case of emergency and hereby give my consent for evaluation and treatment by Dr. Robert Whitson.

Date __________ Patient/Legal Representative ____________________