Welcome to the offices of:
Dr. Michael Wayne & Dr. Justin Steele

Which physician will you see today? (*Circle one*) Dr. Michael Wayne Dr. Justin Steele

Name: _____ __._____ Social Security #:_____
(Last Name) (First Name)

Address: _____Male_____Female _____

_____Date of Birth:_____

Phone #'s: (H)_____ (W) _____ (C)_____

Race:_____ Ethnicity:_____ Primary Language:_____

Email add: _____Emergency contact:_____Phone#_____

Physicians

Primary Care Dr. Name:_____Phone#_____

Primary Care Dr. Address:_____City _____State_____Zip_____

Referring Dr. Name: _____Phone#_____

Referring Dr. Address:_____City_____State_____Zip_____

Billing Information (Primary):

Insurance Co: _____

Insurance ID#: _____

Name of Insured:_____

Relationship to Patient: _____

DOB :_____

Billing Information (Secondary):

Insurance Co: _____

Insurance ID#: _____

Name of Insured:_____

Relationship to Patient: _____

DOB: _____

According to Federal healthcare policy, we are required to submit our prescriptions electronically to your pharmacist.

Pharmacy Name: _____Pharmacy Address:_____

Pharmacy Phone: _____Pharmacy Fax: _____

By my signature below, I certify the information I provided on and in connection with this form is true and accurate

Patient Signature: _____Date: _____