6550 E 71st St, Ste 200
Tulsa, OK 74133
918.260.9322 Phone
918.794.8702 Fax

James R Webb, Jr. M.D. Ryan Pitts, D.O. Jenny Guthrie, APRN CNP

Patient Information Form

Name:______________________________________ Date of Birth:_________________ Sex: M F

Home Phone:_______________________ Cell:____________________ Work:___________________

Social Security #:___________________ Email Address:____________________________________

Home Address:_______________________________ City:_________________ Zip Code:________

Driver's License Number:___________________ State:______ Exp. Date:_____________

Race (Check One): __Caucasian __African American __ Hispanic __ American Indian __Asian

Employer Information

Employer Name:____ Phone:____________________

Spouse's Name:_________________________ Phone:________________ Date of Birth:___________

Emergency Contact?______________________________________ Phone:_____________________

Primary Care Physician:____ Phone:_____________

Referring Physician:____ Phone:_____________

Whom may we thank for referring you to us?___________________________ Phone:_____________

Insurance Information

Insurance Company:___________________ ID#________________Group #__________

Name of Insured:______________________________ Relationship to Patient:_______________

Birthdate:____________________ Social Security Number:________________________

Do you have Secondary Insurance? __Yes __No

Insurance Company:___________________ ID#________________Group #__________

Name of Insured:______________________________ Relationship to Patient:_______________

Birthdate:____________________ Social Security Number:________________________

I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. By signing this form I authorize James R. Webb, Jr., MD., P.C. to release my protected health information to the emergency contact listed above. I will notify you of any changes in my status or the above information.

____ _____________________

Signature Date