DAVID CRAIG WRIGHT, MD

Board Certified in Infectious Disease and Internal Medicine
304 Grand Ave
Pacific Grove, CA 93950
(831) 717-4444

PLEASE PRINT

Patient Name _____

Physical Address _____
Street City, State Zip Code

Mailing Address _____
Street City, State Zip Code

Home Phone # _____ **Email** _____

Work Phone # _____

Cell Phone # _____ **Social Security #** _____

Fax # _____ **Insured's SSN** _____

Sex
Male Female

Marital Status
Single Married Widowed Divorced

Name of Spouse _____

Patient Date of Birth _____ **Insured's Date of Birth** _____

Referring Doctor _____ **Date of Injury** _____

Please circle one: Accident Workers Comp Auto Other

****PLEASE PRESENT INSURANCE CARD(S) AND DRIVERS' LICENSE TO RECEPTIONIST FOR COPYING****

Primary Insurance _____

Secondary Insurance _____

I grant to D. Craig Wright, MD the authority to administer treatments and perform such procedures as may be deemed necessary for the above-named patient. I understand I am financially responsible for services not covered by my insurance. I hereby authorize insurance payments to be made to D. Craig Wright, MD. I also authorize the doctor to release any information required to process my insurance claims. If I go to an unauthorized facility, I will assume full financial responsibility.

CANCELLATION POLICY: I understand that if I fail to appear for a scheduled appointment, or do not cancel my appointment 72 hours in advance, I am responsible and will be charged a $100.00 fee.

MEDICAL RECORDS POLICY: I understand that there will be a fee to copy medical records. The fee shall be $25.00 for fewer than 50 pages of records, and $50.00 for 50 pages of records or more. I also understand that Dr. Wright does not provide additional copies of Quest or LabCorp lab results to patients. At the time of testing, Dr. Wright requests that the lab mail a copy of the results to the patient. This is the only copy the patient will receive. I understand that Dr. Wright does not release lab results to patients until they are final.

_____ _____
Signed **Date**

_____ _____
Relationship to patient (if under 18) **Emergency Contact / Phone / Relationship to Patient**