**Craig M. Wax, D.O., L. L. C. - Family Medicine**
155 North Main St. Mullica Hill, NJ 08062
(856) 478-4780

Welcome to our family medicine office. Please print the following information.

Date______________ SSN__________________________

Name__________________________________________ Date of Birth___________________

Sex___________ Marital Status___________________ Spouse_________________________

Parent or Guardian(if minor) _______________________

Home Address____________________________________________________

City______________________ State___________ Zip______________

Home Phone___________________ Mobile Phone(_____)__________________

Your employer/Spouse's employer____________________________________

Work Address____________________________________________________

City_____________________ State___________ Zip______________

Work phone______________________ Pager/Mobile(_____)__________________

Occupation______________________ How did you hear of the practice? ____________________

Emergency Contact_________________ Phone(_____)___________ Relationship___________

**Insurance Information: Please provide your insurance card.**

**Primary** Insurance Company________________________________

Policy/ID number____________________________ Group number_______________________

Subscriber's name____________________________ Relationship_______________________

**Secondary** Insurance Company______________________________

Policy/ID number____________________________ Group number_______________________

Subscriber's name____________________________ Relationship_______________________

I hereby authorize any insurance benefits to be paid directly to Craig M. Wax, D.O., L.L.C. and I understand that I am financially responsible for non-covered services, deductibles and copayments. I also authorize to Craig M. Wax, D.O., L.L.C. to release to my insurance company any information required to process an insurance claim.

I also acknowledge that I have read and received a copy of the practice's notice of privacy policies. (HIPAA)

Signature______________________________ Date___________________