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_______________

Primary Phone (___)________________ Home ( ) Cell ( )

Alternate Phone (___)________________ Home ( ) Cell ( )

Email _________________________________

Initial here if you **do not** wish us to leave messages about upcoming appointments ________________

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___________________ form 02/02/17