Patient:
Encounter Date/Time:
Contact Serial #:
MRN:

WESTON COUNTY HEALTH FAMILY MEDICINE 1121 WASHINGTON BLVD NEWCASTLE WY 82701-2968

ENCOUNTER

Patient Class:	Unit:
Hospital Service:	**Bed:**
Admitting Provider:	Referring Physician:
Attending Provider:	Adm Diagnosis:

PATIENT

Name:	**DOB:**
Address:	Sex:
City:	SSN:
Primary Care Provider:	Pref Lang:
EMERGENCY CONTACT	Primary Phone:

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone
1.				
2.				

GUARANTOR

Guarantor:	DOB:
Address:	Sex:
Relation to Patient:	Home Phone:
Guarantor ID:	Work Phone:
	Mobile Phone:
GUARANTOR EMPLOYER	
Employer:	Status:

COVERAGE

PRIMARY INSURANCE	
Payor:	Plan:
Group Number:	Insurance Type:
Subscriber Name:	Subscriber DOB:
Subscriber ID:	
Pat. ReL to Subscriber:	
SECONDARY INSURANCE	
Payor:	Plan:
Group Number:	Insurance Type:
Subscriber Name:	Subscriber DOB:
Subscriber ID:	
Pat. Rei. to Subscriber:	