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New Patient Information

Please print.

Date:

PATIENT INFORMATION

Name | Age | Date of Birth

Address | City | Zip

Phone (Home) | Phone (Work) | Phone (Cell)

Employer | Occupation

Social Security # | Driver's License #

SPOUSE & DEPENDENTS

Spouse Name | Spouse Occupation

Names and Ages of Children

INSURED / RESPONSIBLE PARTY — PLEASE COMPLETE REGARDLESS OF INSURANCE COVERAGE

Full Name of Insured | Insurance Company

Occupation | Home Address

Phone # | City/State | Zip

Insured's SS#

Insured's Date of Birth

Insured's Employer

Insured's ID #

Insured's Group #

OFFICE BILLING & INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used with the same force as the original.

By signing below, I confirm that I have read and understand the stated Office Billing & Insurance Policy and that I agree to the regulations.

Signature

Date

Religious Preference (optional):

PRIMARY CARE

Primary Physician Name

Phone

Date Last Seen

Diagnosis

Current Medications

REASON FOR VISIT

Brief statement of reason for this visit

IN CASE OF EMERGENCY — CONTACT INFORMATION

Name

Relationship

Address

City

Zip

Phone (Home)

Phone (Work)

Phone (Cell)

Patient Signature

Parent/Legal Guardian Signature