

NEW PATIENT INFORMATION FORM

LAST NAME _____ FIRST NAME _____ MI _____

DOB _____ AGE _____ SEX: M ___ F ___ SOCIAL SECURITY# _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL# _____
(CIRCLE PREFERRED CONTACT NUMBER)

EMPLOYER _____

MARITAL STATUS: ___S___M___Sep___W___D

SPOUSE'S NAME _____ EMPLOYER _____

PERSON RESPONSIBLE FOR PAYMENT _____
(IF DIFFERENT FROM ABOVE)

ADDRESS _____ CITY _____ STATE _____

ZIP _____ PHONE NUMBER _____ SS# _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT (NAME AND NUMBER) _____

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____

INSURANCE ___SELF PAY___

PRIMARY INSURANCE _____

NAME OF POLICY HOLDER _____ ID# _____

SECONDARY INSURANCE _____

NAME OF POLICY HOLDER _____ ID# _____

I hereby authorize and direct payment to the provider of service for medical benefits, if any, otherwise payable to me under the terms of my insurance (for services not paid at the time). I hereby authorize the provider of service to release any information obtained during the course of my examination/treatment in order to process my insurance claims. I agree that I am financially responsible for charges not covered by my insurance company and will notify this office if at any time my insurance information changes. I hereby understand that in the event I need to cancel an appointment that a 24-hour notice is required, or I will be charged.

SIGNATURE _____ DATE _____