New Patient Information

Welcome to our office. Please complete this form and return it to the receptionist, who will use the information to prepare your chart.

Patient Information

Name_____ Date _____

Street Address _____

City_____ State_____ Zip Code _____

Home Phone_____ Work Phone_____ Cell Phone _____

Date of Birth_____ Age _____ Male/Female_____ Social Security #_____

Email Address_____

Occupation _____ Employer _____

Employer Address/Phone _____

Please circle one: Single Married Widowed Divorced

Name of Spouse _____ Employer _____

Employer Address/Phone _____

Name of referring Physician/Patient _____ Family Physician _____

Responsible Party Information (if not patient)

Name_____ Social Security #_____ Relationship _____

Street Address_____ City _____ State _____ Zip Code_____

Telephone _____ Date of Birth _____

Employer_____ Employer Address _____

Complete if under 18 years of age:

Father's Name _____ Employer _____

Father's Address/Phone _____

Mother's Name _____ Employer _____

Mother's Address/Phone_____

Emergency Contact Not Living in home

Name _____ Relationship _____ Home Telephone _____

Address _____ Work Telephone _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

IF OTHER THAN PATIENT

Insured's Name _____

D.O.B. _____ SSN# _____ Relationship_____

Secondary Insurance_____ ID#_____

IF OTHER THAN PATIENT

Insured's Name _____

D.O.B. _____ SSN# _____ Relationship_____

Authorization to release information:

I hereby authorize the above doctor/doctors to furnish the insured's insurance company all information which said insurance company may request concerning my present or future claims

Assignment of insurance benefits:

I hereby assign the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed by indebtedness to said doctor/doctors. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full unless a request is received from the insurance company for a direct refund of an overpayment in which case a refund will b issued to the insurance company. I understand I am financially responsible to said doctor/doctors for charges.

Assignment of Insurance benefits is designated as lifetime beneficiary authorization.

_____ _____ _____

Responsible Party's Signature **Patient's Signature** **Date**

(if other than Patient)