

# New Patient Information

## PERSONAL INFORMATION (Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M / F \_\_\_\_\_

Soc Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone: Home ( ) Work ( )

Cell # \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Spouse Name \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone ( )

### Complete if under 18 years or a student

Name of Guardian \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone ( )

Referred by :  Friend/Relative \_\_\_\_\_ Doctor \_\_\_\_\_  
Name Name

Yellow Pages  Television  Radio  Website  Other \_\_\_\_\_

## INSURANCE INFORMATION

Medicare # \_\_\_\_\_  Medicaid # \_\_\_\_\_

Workers Compensation (job injury) to whom is bill to be sent? \_\_\_\_\_

Other Medical Insurance \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

Are you personally responsible for the payment of your fees?  Yes  No If not, who is?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) Work Phone ( )

**We may contact you via Phone and Email unless otherwise noted.**

### FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) \_\_\_\_\_ Date \_\_\_\_\_