

NEW PATIENT INFORMATION

Name _____ Date _____

Date of Birth _____ Age _____ M/F _____ Social Security# _____

Address _____

Street

City

State

Zip

Phone: Home _____ Work _____ Email Add _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

Responsible Party (if different from above) _____

Relationship to Patient _____ DOB _____ Soc Security # _____

Address _____ Phone _____

Primary Care Physician _____

Reason for Visit _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____

ID# _____ Grp # _____ ID# _____ Grp # _____

Workers Compensation (job injury) to whom is bill sent? _____

Other Medical Insurance: Grp# _____ ID# _____

Name/Address Insurance _____

Name of nearest relative/friend not living with you _____

Address _____

Home Phone _____ Work Phone _____

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 amounts, co-payments, co-insurance, or any other balance not paid for by your insurance.**

2. IN ORDER TO CONTROL YOU 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 make on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare & Medicaid Services (formerly HCFA), its agents or any insurance carrier I may have , any information needed to determine these 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 information necessary to secure the payment.

Signed (Patient or parent for minor) _____ Date _____