NEW PATIENT INFORMATION

PLEASE PRINT

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ MALE ☐ FEMALE ☐

MAILING ADDRESS: _____ APT/UNIT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

IF PATIENT IS A MINOR, PLEASE CHECK YOUR RELATIONSHIP: ☐ MOM ☐ DAD ☐ GRANDPARENT ☐ OTHER*

*PLEASE SPECIFY: _____

EMPLOYER/SCHOOL: _____ PHONE NUMBER: _____

EMERGENCY CONTACT NAME: _____ PHONE NUMBER: _____

REFERRING DOCTOR: _____ PRACTICE/GROUP: _____

WHO IS RESPONSIBLE FOR YOUR BILL? ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER **(THIS CANNOT BE YOUR INSURANCE COMPANY)**

NAME: _____ DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____

PLEASE LIST THE NAME(S) OF ANY PERSON YOU WISH OUR OFFICE TO DISCUSS YOUR MEDICAL RECORD/FINANCIAL INFORMATION WITH: _____

PLEASE LIST CURRENT INSURANCE COVERAGE(S):

PLEASE LIST THE POLICY HOLDER/SPONSOR'S INFORMATION.

PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED: _____ INSURED DOB: _____

IF TRICARE, SPONSOR'S SOCIAL SECURITY NUMBER: _____ RETIRED MILITARY? ☐ YES ☐ NO

SECONDARY INSURANCE COMPANY: _____

NAME OF INSURED: _____ INSURED DOB: _____

IF TRICARE, SPONSOR'S SOCIAL SECURITY NUMBER: _____ RETIRED MILITARY? ☐ YES ☐ NO

MAY WE LEAVE PERSONAL INFORMATION ON YOUR VOICEMAIL? ☐ YES ☐ NO

I authorize the release of any medical or other information necessary to process my insurance claims. I also authorize payment of benefits to the party or physician who accepts assignment of the claim. I understand that the payment of co-pays, co-insurance, and deductibles is due at the time service is rendered.

_____ _____

Signature **Date**

Please continue on the back of this page. ➡