New Patient Information

PERSONAL INFORMATION (Please Print)

Name ____ Date _________________

Date of Birth ______________ Age _____ ☐ M / ☐ F Social Security #_________________

Address ____

Street City State Zip

Phone: Home (____) ___________ Work (____) __________ Email: ____________________

Occupation ____________________________ Employer ______________________________

Address ____ Phone (____) ______________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name ____________________________ Employer ______________________________

Address ____ Phone (____) ______________

Complete if under 18 years or a student

Name of Father ____________________________ Employer ______________________________

Address ____ Phone (____) ______________

Name of Mother ____________________________ Employer ______________________________

Address ____ Phone (____) ______________

Referred by: ☐ Friend/Relative ____________________ ☐ Doctor _______________________

Name Name

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other _______________________

INSURANCE INFORMATION

☐ Medicare #__________________________ ☐ Medicaid # ___________________________

☐ Workers Compensation (job injury) to whom is bill to be sent? ___________________________

☐ Other Medical Insurance ____

Group # _______________________ ID #_______________________

Name/Address 2nd Insurance ____

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

Name _____________________________ Relationship ______________ DOB ___________

Who to notify in emergency (nearest relative or friend)?

Name ______________________________________ Relationship ______________________

Address ____

Street City State Zip

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 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. I understand that if I miss an appointment, or fail to give 24 hours notice, I will be charged a $50.00 fee.
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. Should my account be turned over to an attorney for collection I will be responsible for attorney fees in the amount of 35% of the principle amount owed and interest in the amount of 18% per annum, compounded monthly. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) ______________________________ Date ______________