

# 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 (\_\_\_\_) \_\_\_\_\_

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 \_\_\_\_\_

Yellow Pages  Television  Newspaper  Other \_\_\_\_\_  
Name Name

## 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.
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 33.3% 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 \_\_\_\_\_