

New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

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

Address _____

Phone: Home () _____ Work () _____

Occupation _____ Employer _____

Address _____ Phone () _____

Marital Status: Single Married Widowed Divorced

Spouse Name _____

Referring Doctor _____ Phone () _____

Medical Doctor _____ Phone () _____

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 _____

Home Phone () _____ Work Phone () _____

Copay _____

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 to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration, its agents, or any insurance carrier I may have.
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 _____