NEW PATIENT INFORMATION FORM

LAST NAME_____ **FIRST NAME**_____ **MI**_____

DOB_____ **AGE**___ **SEX: M**___ **F**___ **SOCIAL SECURITY#**_____

MAILING ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

HOME PHONE_____ **WORK PHONE**_____ **CELL#**_____
(CIRCLE PREFERRED CONTACT NUMBER)

EMPLOYER_____

MARITAL STATUS: ___**S** ___**M** ___**Sep** ___**W** ___**D**

SPOUSE'S NAME_____ **EMPLOYER**_____

PERSON RESPONSIBLE FOR PAYMENT_____
(IF DIFFERENT FROM ABOVE)
ADDRESS_____ **CITY**_____ **STATE**_____

ZIP_____ **PHONE NUMBER**_____ **SS#**_____

RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT (NAME AND NUMBER)_____

REFERRED BY_____ **PRIMARY CARE PHYSICIAN**_____

INSURANCE___ **SELF PAY**___

PRIMARY INSURANCE_____

NAME OF POLICY HOLDER_____ **ID#**_____

SECONDARY INSURANCE_____

NAME OF POLICY HOLDER_____ **ID#**_____

I hereby authorize and direct payment to the provider of service for medical benefits, if any, otherwise payable to me under the terms of my insurance (for services not paid at the time). I hereby authorize the provider of service to release any information obtained during the course of my examination/treatment in order to process my insurance claims. I agree that I am financially responsible for charges not covered by my insurance company and will notify this office if at any time my insurance information changes. I hereby understand that in the event I need to cancel an appointment that a 24-hour notice is required, or I will be charged.

SIGNATURE_____ DATE_____