

New Patient Information Form

Physician: _____ Date: _____

Referring Physician: _____

Patient Complaint or Diagnosis: _____

Patient Information

Name: _____

Age: _____ Date of Birth: _____ SS#: _____

Sex: Male Female Marital Status: _____

Home Address: _____

(Street)

(City)

(State)

(Zip)

Mailing Address: _____

(Street)

(City)

(State)

(Zip)

Home Phone: (____) _____ Business Phone: (____) _____

Employer _____

(Name)

(Address)

Responsible Party: Self or _____

(Relationship)

Name: _____ Phone: (____) _____

Address: _____

(Street)

(City)

(State)

(Zip)

For Emergency Contact Nearest Relative or Friend:

Name: _____ Relationship: _____

Phone: (____) _____

Address: _____

(Street)

(City)

(State/Zip)

Health Care Proxy: Yes No

Health Insurance Information

Primary Health Insurance:

Insurance Company Name: _____

Employer Sponsor: _____

Insurance Address: _____
(Mailing) (City) (State/Zip)

Subscriber relationship to patient: Self Spouse Parent Other

Subscriber Name: _____

Certification ID #: _____ Policy Group or Plan #: _____

Secondary Health Insurance:

Insurance Company Name: _____

Employer Sponsor: _____

Insurance Address: _____
(Mailing) (City) (State/Zip)

Subscriber Relationship to Patient: Self Spouse Parent Other

Subscriber Name: _____

Certification ID #: _____ Policy Group or Plan #: _____

Insurance Authorization and Assignment of Benefits

Please Read:

All charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I hereby authorize and direct payment to **practice name** of all medical/surgical benefits due on any unpaid bills for services provided to me by this physician.

I also authorize release of any information necessary for processing of this or a related claim.

Signature: _____ Date: _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **practice name** for any services provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I hereby authorize Medicare to furnish to the above named practice any information regarding my Medicare claims under title XVIII of the Social Security Act.

Signature: _____ Date: _____