

# New Patient Information

## PERSONAL INFORMATION (Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M/F \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone: Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Spouse Name \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Employer Phone # \_\_\_\_\_

Referred by:  Friend/Relative \_\_\_\_\_  Doctor \_\_\_\_\_

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

## Complete if Under 18 years or a student

Name of Father \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Mother \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

## New Patient Information (continued)

### INSURANCE INFORMATION

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Workers Compensation (job injury) to whom is bill to be sent? \_\_\_\_\_

Other Medical Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

2<sup>nd</sup> Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

### FINANCIAL ASSIGNMENT AND AGREEMENT

1. **We always request payment at time of service. If appointment missed without 24 hour notice there is a \$50.00 charge.**
2. 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.
3. In Order to Control Your Cost of Billings, We Request That Your Charges for Office Visits, Including Deductibles & Copays, Be Paid At The Conclusion of Each Visit. If we are required to use Advanced Collections there is a \$20.00 set up fee & up to 18% interest.
4. 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.
5. 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 \_\_\_\_\_