NEW PATIENT INFORMATION - ADULT

WELCOME TO OUR OFFICE

(PLEASE COMPLETE IN ITS ENTIRETY)

Referred By: ____ Referral's Phone:__________________________________

PATIENT INFORMATION

Patient Last Name:	First:	MI:	SS#:	DOB:	Age:
Street Address with City, State and Zip Code:					
Home Phone:		Cell Phone:		Work Phone:	
Sex:	Marital Status:		Employer:		
Occupation:			Employer's Address:		
Spouse:			Spouse's Employer and Occupation:		
Spouse's Employer's Address:			Spouse's Work Phone:	Spouse's Cell Phone:	
Nearest Relative Not Living With You/Emergency Contact:			Relationship to Patient:	Phone:	

RESPONSIBLE PARTY

Name:	Relationship to Patient:	Phone:	
Address:			
Employer:	Work Phone:	SS#:	DOB:

INSURANCE INFORMATION

Insurer:	Policyholder's Name:
Claims Address:	
Policy # or Subscriber ID #:	Group #:
Secondary Insurance:	Policyholder's Name:
Claims Address:	
Policy # or Subscriber ID#:	Group #:

PLEASE READ:

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 BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT: Name of Policy Holder ____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to ______________________ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

____ ____________________________

SIGNATURE DATE