WELCOME

θ New Patient / θ Name or θ Address or θ Insurance Change / θ Other change

Thank you for selecting our practice! So that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any questions or need assistance, please ask us – we will be happy to help. Thank you.

PATIENT INFORMATION (Please Print) CONFIDENTIAL

Date_________________

Name____ Home Phone (_______)__________________

Mailing Address____________________________________ Mobile (Cell) # (_______)________________

City____ State________ Zip __________________

Alternate Address (if part-time resident)____

Birthdate______________________ Age _____________ Gender: θ Male θ Female

Check appropriate box: θ Minor θ Single θ Married θ Divorced θ Widowed θ Separated

Social Security Number____

Patient's Employer___________________________________ Work Phone (_______)_________________

Business Address____

City____ State________ Zip_________________

If Student, Name of School/College___________________________________ City________________State____________

May we contact you via email? If yes, Email address:____

May we contact you via θ Home or θ Work Fax? If yes, Fax #:____

Person to contact in case of EMERGENCY____ Phone ________________

(Emergency Contact's) Relationship to patient______________________________

Who/What referred you to our Office? θ Doctor θ Patient θ Yellow Pages θ Internet/Website/Search θ Other

Name____ Phone Number__________________

Address____ Fax Number___________________

Website or Search Engine or other referral source____

Medical Doctor_________________________________ Phone #_________________/ Fax #__________________

Address____ Date last seen by this physician______________

RESPONSIBLE PARTY / Name of Insured (if different than Patient)

Name of Person responsible for this account _________________________________ Birthdate__________________

Relationship to Patient____________________________ Social Security Number______________________________

Address____ Home Phone (________)______________

Alternate Address (if part-time resident)____

Driver's License # (& State)______________________________ Financial Institution_______________________________

Employer____ Work Phone (________)________________

Address of Employer____

Date employed_________________________________ Is this person a patient of our office? θ YES θ NO

PLEASE TURN OVER & COMPLETE OTHER SIDE

May we contact you via email? If yes, Email address:____

INSURANCE INFORMATION - Primary

Name of Insured____ Birthdate_____________________

Insurance Co. Name____________________________________ Phone # (______)______________ Ext. _____

Policy or Id Number___________________________ **Group Name or #**___________________________

Policy Type: θ PPO θ POS θ HMO θ Other ______________________________________

Union or Local #____

Insurance Co. Address____

City____ State________ Zip__________________________

How much is your Co-payment for Office visits?______________ How much is your Co-Insurance, if any?_______________

How much is your Deductible?__________________________ And how much have you used?____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE – Secondary Insurance? θ YES θ NO

If yes, complete the following:

Name of Insured____ Birthdate_____________________

Relationship to Patient______________________________ Social Security Number________________________

Employer____ Work Phone (_______)_____________

Address of Employer____

Date employed_____________________________ Is this person a patient of our office? θ YES θ NO

Insurance Co. Name____________________________________ Phone # (______)______________ Ext. _____

Policy or Id Number___________________________ **Group Name or #**___________________________

Policy Type: θ PPO θ POS θ HMO θ Other ______________________________________

Union or Local #____

Insurance Co. Address____

City____ State________ Zip__________________________

How much is your Co-payment for Office visits?______________ How much is your Co-Insurance, if any?_______________

How much is your Deductible?__________________________ How much have you used?_______________________

The above listed contact information shall be used to notify you of personal health information, including billing and past due charges among others, Also, should we need to communicate such info to you, and you are not immediately available via one of your listed contacts, we will provide this information to one of your immediate family members (i.e. spouse or significant other, adult age children and parents) or care-taker/s (via contact information you provide us on this form) unless you specify otherwise in writing here or revoke in the future via certified written letter.

Please document any specific alternative directions here____

____

Also, please provide us with any contact name, relationship, info, not already listed, for those approved to receive your personal health information:

____

X____ Date_______________

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

For Office Use Only:

θ Attach a copy of patient's drivers license (or other form of Id) Staff Initials_________

θ Attach a copy of patient's insurance card or cards (front and back) Staff Initials_________

θ Verify this form is filled out completely, front and back Staff Initials

PLEASE TURN OVER & COMPLETE OTHER SIDE