Adult Medicine New Patient Form

37 South 2nd East, Rexburg, ID 83440 208-356-0234

Patient: ______________________________ Date: ______________

Address: ____
(Mailing) (City) (State) (Zip)

Email Address: ____

Patient SS#: ________________ Birth Date: ______________ Sex: ☐ M ☐ F

Spouse's Name: ________________ SS#: ____________ Birth Date: ____________

Guarantor Information (If different from patient):

Guarantor: ______________________________ Date: ______________

Address: ____
(Mailing) (City) (State) (Zip)

Physical Address: ____
(If different than above)

Guarantor SS#: ________________ Birth Date: ______________ Sex: ☐ M ☐ F

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Emergency Contact:

Name: ____________ Relationship to Patient: ____________ Phone: ____________

Insurance Information:

Primary:

Insurance Company: ______________________ Guarantor: ____________

Relationship to Patient: ____________ Birth Date: ____________ SS#: ____________

ID#: ________________ Group#: ________________

Secondary:

Insurance Company: ______________________ Guarantor: ____________

Relationship to Patient: ____________ Birth Date: ____________ SS#: ____________

ID#: ________________ Group#: ________________

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I assign the benefits payable to which I am entitled, including Medicaid, private insurance and other health plans, to Seasons Adult Medicine and authorize the practice to appeal on my behalf any incorrect insurance payment. This assignment will remain in effect until revoked by me in writing. I have also had the opportunity to review the Notice of Privacy statement, been provided an opportunity to ask

______________________________ ______________
Signature Date

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Main complaint that you are seeing the doctor for today:

____

____

____

Previous and current medical problems:

____

____

____

Previous surgeries:

____

____

____

All medications youa re current on (including non-prescription medications):

____

____

____

Any allergies: ____

Family medical history:

____

____

____

Do you now or have you ever smoked? No Yes (If yes how much)

Do you consume alcohol? No Yes (If yes how much)

What is your profession? ____