Welcome To Our Office

NEW PATIENT INFORMATION

DATE ____________

PATIENT'S NAME (PLEASE PRINT)	S.S. #	MARITAL STATUS: S / M / W / D / SEP	SEX: M / F	BIRTH DATE	AGE	RELIGION (OPTIONAL)
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE			ZIP CODE	HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE # EXT. #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
DRUG ALLERGIES, IF ANY						
SPOUSE OR PARENT'S NAME	S.S. #	BIRTH DATE				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATED IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE			ZIP CODE	HOME PHONE #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE		ZIP CODE	HOME PHONE #
☐ BLUE SHIELD (GIVE NAME OF POLICYHOLDER)	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE
☐ OTHER (WRITE IN NAME OF INSURANCE COMPANY)	EFFECTIVE DATE		POLICY #	
☐ OTHER (WRITE IN NAME OF INSURANCE COMPANY)	EFFECTIVE DATE		POLICY #	

☐ MEDICARE #	☐ RAILROAD RETIREMENT #	☐ VISA or ☐ MASTERCARD #	EXP. DATE /

☐ MEDICAID	EFFECTIVE DATE	PROGRAM #	COUNTY #	CASE #	ACCOUNT #

☐ INDUSTRIAL	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	INDUSTRIAL CLAIM #
☐ ACCIDENT	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY

WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ☐ YES ☐ NO	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)	DATE X-RAYS TAKEN

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.

REFERRED BY	STREET ADDRESS, CITY, STATE	ZIP CODE	PHONE #

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 BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder____________________ HIC Number____________________

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 CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice - I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice; ____________________.

Signature____________________ Date____________________

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