NEW PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

PATIENT INFORMATION

PATIENT'S NAME (LAST,FIRST, MI)	MARITAL STATUS: S / M / W / DIV / SEP	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NO.
STREET ADDRESS / APT. #	CITY AND STATE		ZIP CODE		HOME PHONE NO. ( )
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED?		BUSINESS PHONE NO. ( )
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE
IN CASE OF EMERGENCY CONTACT					DRIVER'S LICENSE NO.
SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NO.		SPOUSE'S DATE OF BIRTH		
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED?		BUSINESS PHONE NO. ( )
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE
WHO REFERRED YOU TO THIS PRACTICE?					

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	BIRTH DATE	STREET ADDRESS CITY, STATE, AND ZIP CODE		HOME PHONE NO. ( )
MOTHER'S EMPLOYER		OCCUPATION	SOCIAL SECURITY NO.	BUSINESS PHONE NO. ( )
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE
FATHER'S NAME	BIRTH DATE	STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO. ( )
FATHER'S EMPLOYER		OCCUPATION	SOCIAL SECURITY NO.	BUSINESS PHONE NO. ( )
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO. ( )

INSURANCE INFORMATION

☐ MEDICARE	MEDICARE #	☐ MEDICAID	MEDICAID #

1. INSURANCE COMPANY NAME	MAILING ADDRESS FOR CLAIMS		INSURANCE TELEPHONE #
NAME OF POLICY HOLDER (SUBSCRIBER)	POLICY #	CERTIFICATE (S.S.#)	GROUP #

2. INSURANCE COMPANY NAME	MAILING ADDRESS FOR CLAIMS		INSURANCE TELEPHONE #
NAME OF POLICY HOLDER (SUBSCRIBER)	POLICY #	CERTIFICATE (S.S.#)	GROUP #

Please sign so we may have your authorization on file.

I authorize any holder of medical or other information about me to release any information from my medical record to any third party payee and to deal directly with any third party on my behalf to determine benefits.

In order to establish optimal realtions with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, check, Master Card, Visa or Discover. In the event of major procedures, our office will file the appropriate insurance. However, you will be asked to pay any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

Signature of Patient, or Parent, or Responsible Party

Date