New Patient Demographic, Insurance, and Billing Information

Please Print Legibly **Date: _____**

Patient: (use full legal name)

_____
Last Name First Name Middle Initial

_____
Maiden or other name(s)

_____ _____ _____
Social Security Number Date of Birth Age

_____
Street Address City State Zip Code

(_____)_____ (_____)_____ Female - Male _____
Home Phone Cell Phone Sex on Insurance Occupation

_____
E-Mail Address

_____ (_____)_____
Employer Name Business Phone

_____ (_____)_____
Emergency Contact & their relationship to you Phone Number

Preferred Method for Appointment Reminders (circle one): Text E-mail Phone

Race (up to two): African American White American Indian Asian Hispanic Other

Are you Hispanic or Latino? ___ Yes ____ No ____ Decline to Provide Information

Marital Status (circle one): Single - Married - Partnered - Widowed - Divorced - Legally Separated

Preferred Language: _____ Preferred Pronouns: she - he - they

Employment Status (circle one): Full-time Part-time Not employed Student Disabled Retired

Student Status (circle one): Full-time Part-time Not a student

Medical Insurance Information:

_____
Primary Insurance Company

_____
Subscriber's Name Subscriber's Date of Birth

_____
Subscriber's Relationship to Patient Subscriber's Employer

_____
Secondary Insurance Company

_____
Subscriber's Name Subscriber's Date of Birth

_____
Subscriber's Relationship to Patient Subscriber's Employer

Injury/Accident Information

Is this visit related to an injury or accident? _____ Yes _____ No

Automobile _____

Home _____

Worker's Compensation _____

Other _____

If Worker's Compensation injury, please complete the following:

_____ _____
Company Name Claim Number

_____ (_____)_____ _____
Company address Company Phone Treatment Authorized By

Responsible Party

If someone other than the patient is responsible for medical bills, please complete the following:

_____ _____ _____
Name Date of Birth Relationship

_____ (_____)_____ (_____)_____
Social Security Number Home Phone Cell Phone

_____
Street Address City State Zip Code

_____
Employer Occupation

_____ (_____)_____
Employer Address City State Zip Business Phone

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 commercial insurance company, any information needed for this or a related Medicare 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. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature of patient or legal guardian Date