

**PATIENT INFORMATION**

New Patient  Name Change  Address Change  Insurance Change

**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Please fill in all lines with an answer.**

**If a question is not applicable please put N/A**

Today's Date \_\_\_ / \_\_\_ / \_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_  
*Last First M.I.*

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Status:  Single  Married  Widowed  Divorced

**ADDRESS:**

Mailing Address \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
*City State Zip*

Cell Phone: ( ) \_\_\_\_\_ e-mail: \_\_\_\_\_

**PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
*City State Zip*

**EMERGENCY CONTACT INFORMATION:**

In case of Emergency, who should be notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
**Last Name First Name**

Preferred Pharmacy \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
**NAME & LOCATION**

**INSURANCE COVERAGE - PRIMARY:**

Insurance Co. Name: \_\_\_\_\_

Address of Claim Center: \_\_\_\_\_

*City State Zip Code*

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Policy #: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Policy Type:  HMO  PPO

If patient is child, check relationship to insured:  Mother  Father  Other \_\_\_\_\_

**INSURANCE COVERAGE - SECONDARY:**

Insurance Co. Name: \_\_\_\_\_

Address of Claim Center: \_\_\_\_\_

\_\_\_\_\_  
City State Zip Code

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_/\_\_\_/\_\_\_

Policy #: \_\_\_\_\_ Group Name or #: \_\_\_\_\_

Policy Type:  HMO  PPO

If patient is child, check relationship to insured:  Mother  Father  Other \_\_\_\_\_

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE**

Patient Name: \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Other family members that are patients \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Last Name First Name

**Do you give our office permission to discuss your medical information with family members?**

YES  NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_\_) \_\_\_\_\_ Phone # (evening): (\_\_\_\_\_) \_\_\_\_\_

**May we leave personal medical information on your answering machine at home?**

YES  NO

**May we e-mail personal medical information to you?**

YES  NO E-mail address: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**PAYMENT POLICY:**

**HMO, PPO or other managed care patients:** You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services at the time of service.

**Commercial Patients:** Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_