New Patient Information Record

First Name: ______________________________ Last Name: ____

Address: ________________________________ City/State: ______________________________ Zip: _______

Home Phone: ___________________ Work Phone: ____________________ Cell: ________________

Date of Birth: ___________________________________ SSN: ______________________________________

E-Mail Address: ____

Employer: ____

Family Physician: ____
(full name and phone no.)

Referring Physician: ____
(full name and phone no.)

If patient is under 18, please complete the following:

Parent/Guardian Name: ____

Address: ____________________________________ City/State: _______________________ Zip: _________

INSURANCE INFORMATION

Insurance Company:____ Phone: ____________________________

Insured ID Number: ____ Group: _____________________________

Policy Holder Name: ____

Policy Holder Employer: ____

Remember, you are responsible for any charges incurred as a result of treatment in our office. We will file your primary claim as a courtesy to you. However, if your claim is denied or not paid in full, payment, in full, is due within 15 days of receipt of our statement to you.

Signature: ____ Date: ___________________________