New Patient Information

Name: ____
(Last) **(First)** **(Middle Initial)**

Address: ____

____

Phone Numbers **Home** ____

Cell ____

Work ____

Date of Birth ______/______/________ **Social Security #** ________-____-__________

Gender **Male** _____ **Female** _____ **Marital Status** ___________ **Race** ____________

Emergency Contact: Name ____

Phone ____

Patient's Employer ____

Address ____

____

Phone ____

*****Guarantor***** ***This is the person responsible for the balance after insurance pays on the Account. If you are 18 yrs. old or older you do not need to answer this section.***

Guarantor Name ____

Address ____

____

Phone ____

Date of Birth ____/____/________ **Social Security #** _______/_______/_________

Guarantor Employer ____

Address ____

____

Phone ____

Insurance Information

Primary Insurance ____

Effective Date ____

Insured ____

Insured's Date of Birth ____/____/_______ **Social Security #** ______/_____/________

Relationship to Patient _____ **Self** _____ **Spouse** _____ **Child**

Policy Number ____

Group Number ____

Insured's Employer ____

Secondary Insurance ____

Effective Date ____

Insured ____

Insured's Date of Birth ____/____/______ **Social Security #** ______/______/_________

Relationship to Patient _____ **Self** _____ **Spouse** _____ **Child**

Policy Number ____

Group Number ____

Authorization: **I will be responsible for any charges not covered by insurance. I Authorize medical evaluation and treatment, and the release of information for insurance/medical purposes concerning my illness and treatment.**

Signature of Authorized Person: ______________________________________

Date: ______________________________________