# WELCOME

❑ New Patient / ❑ Name or ❑ Address or ❑ Insurance Change / ❑ Other change

Thank you for selecting our practice! So that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any questions or need assistance, please ask us – we will be happy to help. Thank you.

**PATIENT INFORMATION** (Please Print) **CONFIDENTIAL** Date_____

Name_____ Home Phone (_____)_____

Mailing Address_____ Mobile (Cell) # (_____)_____

City_____ State_____ Zip _____

Alternate Address (if part-time resident)_____

Birthdate_____ Age _____ Gender: ❑ Male ❑ Female

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Social Security Number_____

Patient's Employer_____ Work Phone (_____)_____

Business Address_____

City_____ State_____ Zip_____

If Student, Name of School/College_____ City_____State_____

May we contact you via email? If yes, Email address:_____

May we contact you via ❑ Home or ❑ Work Fax? If yes, Fax #:_____

Person to contact in case of EMERGENCY_____ Phone _____

(Emergency Contact's) Relationship to patient_____

Who/What referred you to our Office? ❑ Doctor ❑ Patient ❑ Yellow Pages ❑ Internet/Website/Search ❑ Other

Name_____ Phone Number_____

Address_____ Fax Number_____

Website or Search Engine or other referral source_____

***Do you or have you ever written / posted online reviews on**: ❑ Yelp ❑ Angie's List ❑ RealSelf ❑ Other_____

Medical Doctor_____ Phone #_____/ Fax #_____

Address_____ Date last seen by this physician_____

**RESPONSIBLE PARTY / Name of Insured (if different than Patient)**

Name of Person responsible for this account _____ Birthdate_____

Relationship to Patient_____ Social Security Number_____

Address_____ Home Phone (_____)_____

Alternate Address (if part-time resident)_____

Driver's License # (& State)_____ Financial Institution_____

Employer_____ Work Phone (_____)_____

Address of Employer_____

Date employed_____ Is this person a patient of our office? ❑ YES ❑ NO

May we contact you via email? If yes, Email address:_____

**PLEASE TURN OVER & COMPLETE OTHER SIDE**

## INSURANCE INFORMATION - Primary

Name of Insured_____ Birthdate_____

**Insurance Co. Name**_____ Phone # (_____)_____ Ext. _____

**Policy or Id Number**_____ **Group Name or #**_____

Policy Type: ❑ PPO ❑ POS ❑ HMO ❑ Other _____

Union or Local #_____

Insurance Co. Address_____

City_____ State_____ Zip_____

How much is your Co-payment for Office visits?_____ How much is your Co-Insurance, if any?_____

How much is your Deductible?_____ And how much have you used?_____

## DO YOU HAVE ANY ADDITIONAL INSURANCE – Secondary Insurance? ❑ YES ❑ NO

If yes, complete the following:

Name of Insured_____ Birthdate_____

Relationship to Patient_____ Social Security Number_____

Employer_____ Work Phone (_____)_____

Address of Employer_____

Date employed_____ Is this person a patient of our office? ❑ YES ❑ NO

**Insurance Co. Name**_____ Phone # (_____)_____ Ext. _____

**Policy or Id Number**_____ **Group Name or #**_____

Policy Type: ❑ PPO ❑ POS ❑ HMO ❑ Other _____

Union or Local #_____

Insurance Co. Address_____

City_____ State_____ Zip_____

How much is your Co-payment for Office visits?_____ How much is your Co-Insurance, if any?_____

How much is your Deductible?_____ How much have you used?_____

The above listed contact information shall be used to notify you of personal health information, including billing and past due charges among others, Also, should we need to communicate such info to you, and you are not immediately available via one of your listed contacts, we will provide this information to one of your immediate family members (i.e. spouse or significant other, adult age children and parents) or care-taker/s (via contact information you provide us on this form) unless you specify otherwise in writing here or revoke in the future via certified written letter.

Please document any specific alternative directions here_____

_____

Also, please provide us with any contact name, relationship, info, not already listed, for those approved to receive your personal health information:

_____

X_____ Date_____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

For Office Use Only:

❑ Attach a copy of patient's drivers license (or other form of Id) Staff Initials_____

❑ Attach a copy of patient's insurance card or cards (front and back) Staff Initials_____

❑ Verify this form is filled out completely, front and back Staff Initials_____