NEW PATIENT INFORMATION

* Please provide your insurance card to the receptionist prior to completing this form.

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Last Name | First | M.I.

Appt. Date | M / F | DOB | Age | Social Security

Driver's License | Marital status ❍ Single ❍ Married ❍ Seperated ❍ Divorced ❍ Widowed

Address | City | State | Zip

Email | Home/Cell Phone | Work Phone

Occupation | Employer | Employer Address

Referring Doctor | Referring Doctor's Phone | Primary Doctor

PARENT, SPOUSE, OR REPONSIBLE PARTY (if different from patient)

Last Name | First | M.I. | Relationship to Patient

Address | City | State | Zip

Home/Cell Phone | Work Phone | Email

INSURANCE COVERAGE - PRIMARY:

Insurance Co Name

Claim Center Address | City | State | Zip

Name of Policy Holder (Insured) | Policy Holder (Insured) DOB

Policy # | Group Name or # | HMO / PPO

If Parent or Guardian, please specify relationship to the patient ☐ Mother ☐ Father ☐ Other (please explain):

INSURANCE COVERAGE - SECONDARY:

Insurance Co Name

Claim Center Address | City | State | Zip

Name of Policy Holder (Insured) | Policy Holder (Insured) DOB

Policy # | Group Name or # | HMO / PPO

If Parent or Guardian, please specify relationship to the patient ☐ Mother ☐ Father ☐ Other (please explain):

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Benefit Information:

❍ **HMO** ❍ **EPO**

❍ **POS** ❍ **PPO**

Verified (Name):__________________

	In	Out
Deductible	________	________
Coverage	________ %	________%
Out of Pocket	________	________

Co-pay ________ **Day Max** ________

Pre certification ❍ **Yes** ❍ **No**

Authorization Phone # __________________

Authorization # __________________

Authorization Representitive__________________

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