NEW PATIENT INFORMATION

Welcome to our office. Please complete this form and return it to our receptionist along with a copy of your current license and insurance card(s). Your information is **confidential** and will not be released without your authorization.

PLEASE PRINT

NAME____DATE______________
First Middle Last

Address______________________________City___________State_______Zip_______

Date of Birth____________ SS#_____________________ Home Phone_______________

Email Address____

Please circle one: Minor Single Married Divorced Widowed Separated

Employer_____________________ Occupation____________ Work Phone______________

Spouse/Guardian___________________ Employer__________ Work Phone_____________

Insured's
Name_____________________Relationship____________SS#____________DOB_______

Emergency Contact _________________Relationship___________ Phone _______________

Whom may we thank for referring you? ____

Do you have Medical Insurance? ( ) YES ( ) NO. Please give all of your insurance cards to our receptionist upon checking in at every visit so they can be copied and placed into your chart.

Financial Arrangements
For your convenience, we offer the following methods of payment. **Please circle the option that you prefer**. **Although we participate and file most insurances, co-payments, deductibles, and non-covered services are due in full at each appointment. For those insurance plans which we do not participate, payment in full is expected at the time of service.**
CASH CHECK CREDIT CARDS—MASTERCARD—VISA—DISCOVER

Authorization to Release Information
I hereby authorize the above doctors(s) to furnish the insured's insurance company all information which said insurance company may request concerning my claim.

Assignment of Insurance Benefits
I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me. I understand that I am financially responsible to said doctor for charges. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court costs incurred in attempting to collect on the outstanding balance.

____ ____________________
Responsible Person's Signature Date

**Patient records only maintained for six (6) years after last encounter (visit).