

New Patient Information Form

All new patients are required to complete and turn in a New Patient Information Form prior to their first scheduled appointment. You should complete this form prior to the time of your first appointment and present it to the receptionist on the day you arrive to be seen.

PATIENT:

Last Name First Name Middle Initial/Name

Sex: Male Female Age _____ Date of Birth _____ Social Security Number _____

Patient Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile Phone _____

* Please Note: A message may be left regarding your appointment at any number you give. *

Requesting MD _____ Requesting MD Location _____

EMPLOYER:

Employed? Yes No

Employer Company Name _____

Employer Address _____

City _____ State _____ Zip Code _____

Patient Occupation _____ Patient Work Phone _____

EMERGENCY CONTACT:

Relationship to Insured Self Spouse Child Other

Name of Nearest Relative _____ Nearest Relative's Relationship _____

Address _____

City _____ State _____ Zip Code _____

Daytime Phone _____ Evening Phone _____

Insurance Information

PRIMARY INSURANCE:

Policy Holder Name _____ Date of Birth _____

Group Number _____ Policy ID Number _____

Social Security Number _____ Relationship to Patient _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip Code _____

Policy Holder Employer _____

Insurance Information (Cont.)

SECONDARY INSURANCE: (if applicable)

Policy Holder Name _____ Date of Birth _____
Group Number _____ Policy ID Number _____
Social Security Number _____ Relationship to Patient _____
Insurance Company Name _____
Address _____
City _____ State _____ Zip Code _____
Policy Holder Employer _____

AUTOMOBILE INSURANCE: (if applicable)

Policy Holder Name _____ Date of Accident _____
Claim Number _____ Policy ID Number _____
Auto Insurance Co. Name _____
Address _____
City _____ State _____ Zip Code _____
Adjustor _____ Phone Number _____

WORKER'S COMPENSATION INSURANCE: (if applicable)

Responsible Employer _____ Date of Injury _____
(if different from Patient Employer listed prior)
Claim Number _____ Policy ID Number _____
Insurance Company Name _____
Address _____
City _____ State _____ Zip Code _____
Case Manager _____ Phone Number _____

POWER OF ATTORNEY AND ADVANCED DIRECTIVES:

Do you have power of Attorney, Guardianship, etc..? Yes No If Yes, please provide a copy to our office for your chart.
Do you have Advanced Directives (I.E. Living Will)? Yes No If Yes, please provide a copy to our office for your chart.
Would you like more information about Advanced Directives? Yes No
Brochure Given to Patient _____ (Staff Initials) _____ (Date)
