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New Patient Information Sheet

PATIENT INFORMATION

Name: (First) _____ (MI) _____ (Last) _____
Date of Birth _____ Age _____ Sex()M () F
Address _____

Telephone _____ Fax _____
Cell _____ Social Security # _____

RESPONSIBLE PARTY

Name: (First) _____ (MI) _____ (Last) _____
Relationship to Patient: ()Self ()Mother ()Father ()Other
Date of Birth _____ Age _____ Sex()M () F
Address: _____

Telephone _____ Fax _____
Cell _____ Social Security # _____
Employer _____ Work Phone _____
Employer's Address _____

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____
Primary Insurance Co. _____ Copay \$ _____
Insurance Address _____ Phone _____
Group # _____ Certification or ID # _____
Insured's Name _____ Relationship ()Self ()Spouse () Dependent
Insured's Social Security # _____ Date of Birth _____ Sex ()M ()F
Insured's Employer _____ Work Phone _____
Employer's Address _____

Secondary Insurance Co. _____ Copay \$ _____
Insurance Address _____ Phone _____
Group # _____ Certification or ID # _____
Insured's Name _____ Relationship ()Self ()Spouse () Dependent
Insured's Social Security # _____ Date of Birth _____ Sex ()M ()F
Insured's Employer _____ Work Phone _____
Employer's Address _____

I hereby assign, transfer and set over to the SMITH HOUSE HEALTH CARE CENTER all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine those benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE COMPANY.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE _____