

Smith House Family Health Care Center
39 Farrell Road, Willsboro, NY 12996
Telephone (518) 963-4275, Fax (518) 963-8862

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

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____
Primary Insurance Co: _____ CO-PAY \$ _____
Insurance Address: _____ Phone _____
Group # _____ Certificate or ID # _____
Insured's Name: _____
Relationship to Patient: () Self () Spouse () Dependent
Insured's Social Security # _____ Date of Birth _____ Sex () M () F
Insured's Employer: _____ Work Phone _____
Employer's Address: _____

Secondary Insurance Co: _____ CO-PAY \$ _____
Insurance Address: _____ Phone _____
Group # _____ Certificate or ID # _____
Insured's Name: _____
Relationship to Patient: () Self () Spouse () Dependent
Insured's Social Security # _____ Date of Birth _____ Sex () M () F

I hereby assign, transfer and set over to the SMITH HOUST FAMILY 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 ME INSURANCE COMPANY.

SIGNATURE OF RESPONSIBLE PARTY: _____ Date: _____