NEW PATIENT FORM

Date_____ **Home Phone**_____

Patient Name_____
(Last) (First) (M.I.)
Responsible Party (if a minor) _____**Relationship**_____

Address_____

City_____ **State**_____ **Zip**_____

Email Address_____ **Cell**_____

Sex: M F Age____ **Birthdate** _____ **Married Single Widow Divorced Separated**

Patient/ Guardian Employer_____

Occupation_____ **Work Phone**_____

Social Security# _____ **Spouse's SSN**_____

Name of Primary Insurance Company_____

Name of Primary insurer_____ **Relation to insurer**_____

Policy# _____ **Group#** _____ **Group Name**_____

Name of Secondary Insurance Company _____

Name of Secondary insurer_____ **Relation to insurer**_____

Policy# _____ **Group#** _____ **Group Name**_____

In Case of Emergency Notify_____

Phone# _____ **Relationship** _____

What Medications are you allergic to? _____

ALL SERVICE MUST BE PAID FOR AT THE TIME THEY ARE RENDERED, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE. FURTHERMORE, WE REQUIRE A TWENTY-FOUR (24) HOUR NOTICE FOR CANCELLATIONS OR A MINIMUM FEE OF $25 (TWENTY-FIVE DOLLARS) WILL BE CHARGED.

Financial responsibility: The undersigned agrees whether he signs as an agent, or as a patient, that in consideration of services rendered to the patient he obligates himself to pay the account of the doctor's bill. Should the account be referred to any attorney for collection, the undersigned shall pay any reasonable attorney fee and collection expenses. All delinquent accounts will bear a service charge of $5.00 per month.

I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed: _____ Date: _____