

# NEW PATIENT INTAKE FORM

## PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME <b>John</b>		LAST NAME <b>Schmidt</b>		DATE OF BIRTH <b>01 / 02 / 03</b>	
SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		SOCIAL SECURITY <b>123-45-6789</b>		PHONE NUMBER <b>867-5309</b>	
EMAIL ADDRESS <b>j.h.jingle.schmidt@gmail.com</b>					
ADDRESS <b>42 Wallaby Way</b>					
CITY <b>Sydney</b>				STATE <b>CA</b>	
ZIP CODE <b>93925</b>					
MARITAL STATUS <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		SPOUSES NAME		SPOUSE PHONE NUMBER	
EMERGENCY CONTACT		RELATIONSHIP		PHONE NUMBER	

## INSURANCE INFORMATION

DO YOU HAVE INSURANCE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		PRIMARY CARD HOLDER <input checked="" type="checkbox"/> SELF <input type="checkbox"/> SPOUSE. <input type="checkbox"/> PARENT. <input type="checkbox"/> OTHER		PRIMARY POLICY HOLDER NAME <b>John Jacob Jingleheimer Schmidt</b>	
PRIMARY INSURANCE COMPANY <b>Aetna</b>		PRIMARY ID NUMBER <b>12345-998</b>		PRIMARY GROUP NUMBER <b>437</b>	
DO YOU HAVE SECONDARY INSURANCE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SECONDARY CARD HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE. <input type="checkbox"/> PARENT. <input type="checkbox"/> OTHER		SECONDARY POLICY HOLDER NAME	
SECONDARY INSURANCE COMPANY		SECONDARY ID NUMBER		SECONDARY GROUP NUMBER	

## PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
  - \$5 Fee for Co-pays not paid at the time of service.
- \$50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
  - \$35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

## PRESCRIPTION POLICY

PHARMACY NAME <b>CVS Pharmacy</b>		PHARMACY PHONE NUMBER <b>800-588-2300</b>	
<ul style="list-style-type: none"> <li>Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.</li> </ul>			

PATIENT SIGNATURE <b>John Jacob Jingleheimer Schmidt</b>		DATE <b>Jan 31, 2025</b>	
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