NEW PATIENT INFORMATION

Patient Last Name _____ First _____ Middle _____

Home Address _____ City _____ Zip _____

Home Phone# _____ Cellphone# _____ Work Phone# _____

Sex: M/F DOB: _____/_____/_____ S.S.# _____/_____/_____ Email _____

Employer _____ Occupation _____ Address _____

Marital Status: ___ Single ___Married ___Divorced ___Widow Reffered by: _____

Emergency Contact _____ Phone # _____ Relation _____

Family Doctor _____ Phone # _____ Pharm # _____

*************Please provide your insurance card & drivers license so a copy can be made *************

Primary Ins _____ Insured's name _____ DOB: ____/____/____

Relationship to Patient _____ ID # _____ Group # _____

Insured's Employer _____ Work # ____/____/____ Insured's S.S. # ____/____/____

Secondary Ins _____ Insured's name _____ DOB: ____/____/____

Relationship to Patient _____ ID # _____ Group # _____

Insured's Employer _____ Work # ____/____/____ Insured's S.S. # ____/____/____

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METHOD OF PAYMENT

Party responsible for payment _____ Relationship _____

To our patients who present insurance information: please be advised that your insurance coverage is subject to all terms and provisions of your plan applicable at the time services are rendered. We will make an attempt to verify your coverage on current information available. Patients must meet eligibility requirements of the plan to have benefits available for service. I understand that I am fully responsible for all amounts not paid by insurance.

I hereby authorize Dr. Maria C. Yango-Eugenio for treatment of condition. I authorize Dr. Yango to release information to insurance companies regarding care rendered. I further authorize direct payment to say doctor for benefits due to me for services rendered and authorize my insurance company to make such payment.

In the event that I have a high deductible or co-insurance, I authorize the billing department to withdraw monthly payments starting at $_____ (dependent of balance) from a credit card provided below.

Credit Card Type____ #_____ Exp date_____Name _____

Signature of Patient/Responsible Party _____ Date _____/_____/_____

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How did you hear about us?

_____ Facebook _____ Instagram _____ Google search ____ Other internet search