NEW PATIENT INFORMATION

Patient Last Name_____ **First**_____ **Middle**_____

Home Address_____ **City**_____ **Zip**_____

Home Phone#_____**Cell Phone#**_____**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**************

INSURANCE DETAILS

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.#**_____/_____/_____

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** _____/_____/_____

How did you hear about us?

_____ Facebook _____ Instagram _____ Google search ____ Other internet search