New Patient Intake Form

Date:_____

Name:_____

Address: _____

City: _____

State: _____ Zip:_____

SSN: _____

Primary Phone: (_____) _____

Alt. Phone: (_____) _____

Sex: ☐ Male ☐ Female **Birthdate:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Preferred Language: ☐ English ☐ Spanish

Other: _____

Race: ☐ Caucasian ☐ African American ☐ Asian

☐American Indian/Alaska Native ☐ Pacific Islander

Ethnicity: Hispanic or Latino ☐Yes ☐No

Employment: ☐ Full Time ☐ Part Time
☐ Retired ☐ Unemployed

Occupation_____

Student Status: ☐ Full Time ☐ Part-Time

Physician who referred you?

_____

GUARDIAN/LEGAL REPRESENTATIVE

If you are not financially responsible for payment for your services, please write the information for the responsible party below.

Name: _____

Address: _____
(Write "Same" if you live with the guardian/legal representative)

City: _____

State: _____ Zip: _____

Primary Phone: (_____) _____

INSURANCE:
Please provide us with your drivers license/state ID and all current insurance cards upon arriving for your visit.

Primary Insurance:_____

Primary Insurance ID #: _____

Primary Insurance Group #: _____

Are you the subscriber or dependent of subscriber?

☐ Subscriber ☐ Dependent

If Dependent, **please write the subscriber information**.

Name: _____

Address: _____
(Write "Same" if you live with the subscriber)

City: _____

State: _____ Zip: _____

Primary Phone: (_____) _____

Birthdate: _____

Patient's Relationship to Subscriber:

☐Spouse ☐ Child Other: _____

Do you have another medical insurance plan?

☐Yes ☐No If Yes: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I am covered by the above listed medical insurance and I agree to assign all benefits, if any, otherwise payable to me directly to the provider of care for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining verification of insurance eligibility, determining insurance benefits payable for services and for obtaining payment for services provided to me.

I understand that my insurance may only pay a portion of the fee for the services provided. I understand that there may be a co-payment required at the time of my visit and there may be a balance remaining (or co-insurance) for which I am personally responsible for paying. I understand that co-payments are due and must be paid at the time of my visit.

_____
Signature of person assigned with financial responsibility for patient.

_____
Print the name of the person assigned with financial responsibility for patient.

_____ _____