



NEW PATIENT INFORMATION

Welcome to Our Office.

DATE: ___/___/___

Patient's Name (Please Print.)	S.S.#	Marital Status					Sex		Birth Date	Age	Religion (Optional)
		S	M	W	D	SEP	M	F			
Mailing Address		City and State				Zip Code		Home Phone #			
Patient's or Guardian's Employer		Occupation (Indicate if Student.)				How Long Employed?		Bus. Phone #/Ext. #			
Employer's Street Address		City and State				Zip Code					
Spouse or Parent's Name		S.S. #				Birth Date					
Spouse or Parent's Employer		Occupation (Indicate if Student.)				Bus. Phone #/Ext. #					
Employer's Street Address		City and State				Zip Code					

How did you hear about our clinic? Yellow Pages Friend/Family Member Newspaper, Radio, Etc.

REFERRED BY: _____
Name Street Address City, State Zip Phone #

1. Person Responsible for Payment, If Not Above		Street Address, City, State			Zip Code	Home Phone #
2. Medicare #			Medicaid #			
3. Insurance Name		Policy #			Group #	
Insured's Name		Insured's S.S.#		Birth Date	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	
4. Other Insurance Name		Policy #			Group #	
Insured's Name		Insured's S.S.#		Insured's Birth Date	Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	
5. Was this Illness Related to an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident	Was an Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Responsible Party Name Phone #	
Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident	Workers' Compensation Carrier			Claim #
9. Were X-rays Taken of This Injury or Problem? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Where Were the X-rays Taken (Hospital, Etc.)?				Date X-rays Taken

Please Read: All charges are due at the time of services. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization, and all charges must be paid within 60 days of discharge.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It also is customary to pay for all services when rendered.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder: _____ HIC Number: _____

I request that payment of authorized Medicare/other insurance company benefits be made to either me or on my behalf to North Oaks for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment to benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)