

Welcome To Our Office

NEW PATIENT INFORMATION

DATE

PATIENT'S NAME (PLEASE PRINT) S.S. # MARITAL STATUS SEX AGE DATE OF BIRTH
STREET ADDRESS PERMANENT TEMPORARY CITY AND STATE ZIP CODE HOME PHONE #
EMAIL ADDRESS
PATIENT'S OR PARENT'S EMPLOYER OCCUPATION (INDICATE IF STUDENT) HOW LONG EMPLOYED BUS. PHONE # EXT. #
EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE
RACE DRUG ALLERGIES, IF ANY
CAUCASIAN AFRICAN AMERICAN HISPANIC OTHER
SPOUSE OR PARENT'S NAME S.S. # BIRTH DATE
SPOUSE OR PARENT'S EMPLOYER OCCUPATION (INDICATED IF STUDENT) HOW LONG EMPLOYED BUS. PHONE #
EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED CITY AND STATE ZIP CODE HOME PHONE #

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE STREET ADDRESS, CITY, STATE ZIP CODE HOME PHONE #
PRIMARY INSURANCE COMPANY EFFECTIVE DATE
POLICY HOLDER NAME DATE OF BIRTH S.S.#
SECONDARY INSURANCE COMPANY EFFECTIVE DATE
POLICY HOLDER NAME DATE OF BIRTH S.S.#
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF FAMILY MEMBER.
REFERRED BY

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES.

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 IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Anthony Medical Clinic for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS 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.)

Acknowledgment of Receipt of Privacy Notice - I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice;

Ok to contact by phone by email by mail Ok to leave message Other

Signature Date

I give my permission for my personal health information to be disclosed to:

Name Relationship Date

Name Relationship Date

Signature Date