

NEW PATIENT FORM

APPOINTMENT DATE: _____

NAME: _____ guardian: _____

PHONE: (H) _____ (fax) _____

(C) _____ (W) _____

EMAIL: _____

MAILING ADDRESS: _____

UPS ADDRESS: _____

AGE: _____ DATE OF BIRTH: ____/____/____ HEIGHT: _____ WEIGHT: _____

ALLERGIES: _____

SUPERBILL FOR YOUR INSURANCE

We don't take any insurance except Medicare, but we can give you a form to submit to your insurance company for possible reimbursement. Would you like a form? Y____N____

If YES, do you want nutritional supplements included in the form? Y____N____

*** PLEASE NOTIFY YOUR COMPANY THAT DR. COWAN IS A PAY UP FRONT PHYSICIAN AND TO SEND CLAIM QUESTIONS AND CHECKS TO YOU DIRECTLY INSTEAD OF THE OFFICE***

CREDIT CARD# (for re-ordering meds/phone consults): _____ exp _____

MEDICARE PATIENTS

Please note we *cannot* accept Medicare that is provided through an HMO

MEDICARE# _____

Have you paid your deductible for this year? Y____N____

SECONDARY INSURANCE NAME and GROUP #(Medicare patients only):

TODAY'S APPOINTMENT

In one sentence or less, please describe what brings you or you child here today:
