

NEW PATIENT FORM

(* indicates required info)

APPOINTMENT DATE: _____

*PATIENT NAME: _____ parent/contact person: _____

*PHONE: (H) _____ (C) _____ (W) _____

*EMAIL: _____ would you like to go paperless with your receipts? **Y N**

*MAILING ADDRESS: _____

*UPS ADDRESS: _____

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

*ALLERGIES: _____

*TODAY'S APPOINTMENT

In one sentence or less, please describe what brings you or your family member here today:

PAYMENT AND INSURANCE OPTIONS

*DEBIT or CREDIT CARD (required for all patients): _____ exp _____

Name on card: _____ address: _____

Back-up card (required for CSH) _____ exp _____

Name on card: _____ address: _____

***Billing Agreement:** I give my permission to run my card after 60 days of overdue charges if no prior pay agreements have been made:

*Signed: _____ Date: _____

COMMUNITY SUPPORTED HEALTH CARE PLAN Through Us (please see laminate & fill out following sheet) **Y N**

SUPERBILL FOR YOUR OWN 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** >>>Please notify your company to send checks to you instead of our office<<<

MEDICARE

>>>Please note we **cannot accept Medicare** that is provided through an **HMO** or as a **Secondary Insurance**.<<<

MEDICARE# _____ (primary insurance only) Have you paid your deductible for this year? **Y N**

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

Company: _____ Group #: _____

Phone: _____ Address: _____