

# NEW PATIENT FORM

APPOINTMENT DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ parent/contact person: \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

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

MAILING ADDRESS: \_\_\_\_\_

UPS ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you are seeking Dr. Cowan for cancer treatment?  Yes  No

## PAYMENT AND INSURANCE OPTIONS

### \*REQUIRED FOR ALL PATIENTS

\*Debit or Credit card: \_\_\_\_\_ exp \_\_\_\_\_

Name on card: \_\_\_\_\_ address #: \_\_\_\_\_ zip code: \_\_\_\_\_

\*Back-up card (credit or debit): \_\_\_\_\_ exp \_\_\_\_\_

Name on card: \_\_\_\_\_ address #: \_\_\_\_\_ zip code: \_\_\_\_\_

**\*Billing Agreement:** I give my permission to run my card after 30 days of overdue charges if no prior pay agreements have been made:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Phone approval on terms

Would you like to contribute to our medicine fund for seriously ill patients? **Y N** Monthly or One-time? \$ \_\_\_\_\_

### COMMUNITY SUPPORTED HEALTH CARE PLAN THROUGH US (see following form & laminate) **Y N**

Phone approval on CSH terms

### 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.\*\*\***

MEDICARE# \_\_\_\_\_ Have you paid your deductible for this year? **Y N**

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

Company: \_\_\_\_\_

Group #: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

# MEDICAL INFORMATION FORM

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

Female  Male

Hispanic  Non-Hispanic  Prefer not to say

Race(s): \_\_\_\_\_ Primary Language: \_\_\_\_\_  Prefer not to say

Smoking Status:  0 cigarettes per day (non-smoker or less than 100 in lifetime)  
 0 cigarettes per day (previous smoker)  
 few (1-3) cigarettes per day  
 up to one pack per day  current tobacco user  
 1-2 packs per day  not a current tobacco user  
 2 or more packs per day

CHIEF COMPLAINT:

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ALLERGIES (food, environmental, medicines):

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PAST MEDICAL HISTORY:

Major events, hospitalizations, surgeries

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Ongoing medical problems:

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Family medical history:

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Preventative care:

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Social history (smoking, drugs, sexual activity, etc):

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Nutrition history:

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Developmental history:

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