FAMILY MEDICINE

Date ___________

New Patient Form

Patient Name ______________________________________

Spouse's Name ______________________________________

Date of Birth ____________ Sex ___ SSN ______________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address ______________________________________

____

E-Mail ______________________________________

☐ Home phone ____________ ☐ Cellular ____________

☐ Other phone ____________ (Check preferred)

Whom may we thank for referring you?

____

Occupation ______________________________________

Employer/School ______________________________________

Race ☐ White ☐ Hispanic ☐ Asian
☐ African American ☐ American Indian
☐ Other ☐ Prefer not to answer

Ethnicity ☐ Hispanic ☐ Non-Hispanic
☐ Prefer not to answer

Primary Language ______________________________________

Local Pharmacy Name/Phone ______________________________

____

Emergency Contact

Name ______________________________________

Relationship ______________________ Phone ____________

Insurance Information

Responsible Party ______________________________________

Relationship to Patient ______________________________________

Insurance Company ______________________________________

Group Number ______________________________________

Is the patient covered by additional insurance? ☐ Yes ☐ No

Additional Insurance Information

Subscriber name ______________________________________

Relationship to Patient ______________________________________

Insurance Company ______________________________________

Group Number ______________________________________

Insurance Assignment and Release

I certify that I have insurance coverage with

____
Name of Insurance Company/Companies

and assign directly to Dr. ________________ all insurance benefits, if any, otherwise payable to me for all charged whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company (or companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to ____________________ for any services furnished to me by that provider.
Name of Doctor or Clinic

____
Signature of Beneficiary, Guardian, or Personal Representative

____
Printed name of Beneficiary, Guardian, or Personal Representative

Date ____________ Relationship to Beneficiary __________________

Date of last physical exam __________ Reason for visit ______________________________________

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