

## New Patient Information Form

Please fill in the following information as completely as possible.

**Guarantor (Responsible Party) Information:**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Advanced Directive: Yes \_\_\_ No \_\_\_  
 Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_ Decline to Answer \_\_\_\_\_

**Patient Information:**

Relation to Guarantor: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Maiden Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Last Visit \_\_\_\_\_  
 Address \_\_\_\_\_  
 Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Email \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status \_\_\_ Sex \_\_\_ Work Ph (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Ph (\_\_\_\_) \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_ Decline to Answer \_\_\_\_\_  
 Student: Yes \_\_\_ No \_\_\_ Full-time \_\_\_ Part-time \_\_\_ Name of School \_\_\_\_\_  
 Is today's visit the result of auto accident? Yes \_\_\_ No \_\_\_ Work Injury? \_\_\_ Date \_\_\_\_\_  
 Other Coverage \_\_\_\_\_  
 Spouse Name \_\_\_\_\_ Employer \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Insured (Policyholder) Information---Primary Carrier:**

Please present your insurance card(s) to front counter.

Ins Co Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Address 1 \_\_\_\_\_ Group # \_\_\_\_\_  
 Address 2/City St Zip \_\_\_\_\_  
 Patient Relation to Insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_  
 Policy Holder Name/Address 1 \_\_\_\_\_  
 Address 2/City St Zip \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_  
 Employer \_\_\_\_\_

**Insured (Policyholder) Information---Secondary Carrier:**

Ins Co Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 Address 1 \_\_\_\_\_ Group # \_\_\_\_\_  
 Address 2/City St Zip \_\_\_\_\_  
 Patient Relation to Insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_  
 Policy Holder Name/Address 1 \_\_\_\_\_  
 Address 2/City St Zip \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_  
 Employer \_\_\_\_\_

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to MICHAEL J FREEMAN, MD, P.A.. I understand payment is due at time of service.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

