NEW ACCOUNT FORM

Patient Name ______________________________ **Maiden Name** ____________
Last First Middle

Mailing Address ______________________________

City ______________ **ST** ______ **Zip Code** ______________

Home Phone ______________ **Work** ______________ **Cell** ______________

Place of Employment ______________________________

_____ **Single** _____ **Married** _____ **Widowed** _____ **Divorced**

Date of Birth ______________ **Social Security #** ______________

Referring Physician ______________________________

Responsible Party ______________________________

Name of Spouse ______________________________

Spouse Employment ______________________________

Spouse Date of Birth ______________ **Social Security #** ______________

Insurance Company ______________________________

Address ______________________________

Policy # ______________ **Group #** ______________

Policy Holder ______________________________

Medicare # ______________________________

Medicaid # ______________________________

PCP For Medicaid ______________________________

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD

Financial Arrangements

We will submit insurance claims if insurance information is provided to our office. All co-pays are expected to be paid the day of service.

If no insurance information is provided, payment is expected the day care is provided unless prior arrangements are made for a payment plan.

I, ______________________ have read the foregoing financial policy and declare that I understand it s contents and do agree to its terms.

______________________________ ______________

Signature of Patient (If patient is a minor, signature of parent /guardian) Date