NEW PATIENT INFORMATION SHEET

DATE OF CALL _____ FIRST APPT _____ **OFFICE / HC** IN **A² / Y / D / C**

PATIENT NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ ZIP _____

PHONE (____) _____ SSN _____ **M / F** MARITAL STATUS _____

CONTACT PERSON _____ PHONE (____) _____

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____ PHONE (____) _____

CHIEF COMPLAINT _____

_____

MEDICAL HISTORY (DIABETES, VASCULAR DISEASE, ETC.) _____

_____

DRUG ALLERGIES **NONE** _____

CURRENT MEDICATIONS _____

_____

_____

SEND BILLS TO _____ RELATIONSHIP _____ PHONE (____) _____

ADDRESS _____ CITY _____ ZIP _____

– INDICATE PRIMARY INSURANCE CARRIER –

MEDICARE # _____ MEDICAID # _____

BENEFITS: ELIGIBILE _____ DEDUCTIBLE _____ PRIMARY _____ HMO _____

BLUE CROSS # _____ GROUP # _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

CLAIMS ADDRESS _____ PHONE (____) _____

OTHER INSURANCE NAME _____ PHONE (_____) _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

ID # _____ EMPLOYER/GROUP NAME _____

BILLING ADDRESS _____ CITY _____ ZIP _____