

NEW PATIENT INFORMATION RECORD

(PLEASE PRINT)

PATIENT INFORMATION (*Required fields)

PATIENT'S NAME*	SEX	AGE	DATE OF BIRTH*	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER
MAILING ADDRESS*	CITY AND STATE		ZIP CODE*	HOME PHONE NUMBER*	
EMAIL ADDRESS				CELL PHONE NUMBER	
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE NUMBER		
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE	
SPOUSE'S NAME			SOCIAL SECURITY NUMBER		
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE NUMBER		
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE	
REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN**			PHONE NUMBER		

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	DATE OF BIRTH	MAILING ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER
MOTHER'S EMPLOYER	OCCUPATION	SOCIAL SECURITY NUMBER	BUSINESS PHONE NUMBER
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE
FATHER'S NAME	DATE OF BIRTH	MAILING ADDRESS, CITY, STATE, ZIP	HOME PHONE NUMBER
FATHER'S EMPLOYER	OCCUPATION	SOCIAL SECURITY NUMBER	BUSINESS PHONE NUMBER
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE

EMERGENCY CONTACT*

NAME	PHONE NUMBER	RELATIONSHIP
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INSURANCE INFORMATION

PRIMARY INSURANCE*	EFFECTIVE DATE*	I.D. #	GROUP #
NAME AND ADDRESS			
POLICY HOLDER'S NAME*	DATE OF BIRTH**	SEX	GROUP #
SECONDARY INSURANCE*	EFFECTIVE DATE*	I.D. #	GROUP #
NAME AND ADDRESS			
POLICY HOLDER'S NAME*	DATE OF BIRTH**	SEX	GROUP #

It is the responsibility of the patient to understand the policies and benefits of their insurance. This includes (1) required referrals obtained and presented prior to services rendered; (2) co-payments; (3) covered benefits; (4) prior authorization procedures. We require co-payments to be paid on the date of service rendered. ASSIGNMENT OF BENEFITS: I hereby authorize the undersigned physician to furnish information to insurance carriers concerning this illness/accident. And I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original. I authorize the physicians and extenders of Capital Allergy and Respiratory Disease Center to perform such diagnostic procedures and/or treatment, as they deem necessary.

PATIENT/INSURED SIGNATURE _____

DATE _____