

Patient # _____

NEW PATIENT INFORMATION FORM

Last Name _____ First _____ Middle _____

Street _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Birth Date _____ Sex M F

Social Security # _____ Marital Status - M S D W

Primary Care Physician _____ Phone _____

Occupation _____ Employer _____

Street _____ City/ST _____ Zip _____

Work Phone _____

RESPONSIBLE PARTY (if under age 18)

Name _____ Relation _____

Address (if different than above) _____

Phone _____

How did you hear about our office?

Referred by Dr. _____ Insurance Directory _____

Friend _____ Internet _____

Phone Book ___SBC/SNET Yellow pages ___ Yellowbook ___ Transwestern Yellow Pages

Other _____

PRIMARY INSURANCE

Subscriber (if other than self) _____ DOB _____

*Please provide your card to the receptionist so we can make a copy for our records.

SECONDARY INSURANCE

Subscriber (if other than self) _____ DOB _____

EMERGENCY CONTACT

PHONE _____

I authorize the release of medical information necessary to process any claim. I authorize payment of benefits either to myself or to DRS YALE AND HENDIZADEH as agreed upon at the time of treatment for services rendered. I further agree to be responsible for reasonable fees associated with the cost of collection on my account if not paid in full within 60 days of treatment. I give permission to be contacted via phone or mail.

SIGNATURE _____

DATE _____

FOR OFFICE USE ONLY: INPUT BY _____

revised 2/04