

NEW PATIENT INFORMATION

FATHER'S INFORMATION

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____
ADDRESS _____ HOME PHONE _____
_____ WORK PHONE _____
EMPLOYER _____ OCCUPATION _____
INSURANCE CARRIER _____ BIRTHDATE _____
SOCIAL SECURITY NO. _____

MOTHER'S INFORMATION

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____
MOTHER'S MAIDEN NAME _____
ADDRESS _____ HOME PHONE _____
_____ WORK PHONE _____
EMPLOYER _____ OCCUPATION _____
INSURANCE CARRIER _____ BIRTHDATE _____
SOCIAL SECURITY NO. _____

CHILDREN

LAST NAME, FIRST NAME, MIDDLE INITIAL	BIRTHDATE	GENDER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

FINANCIAL RESPONSIBILITY

As a courtesy, our practice will file your claim electronically with your insurance company. You will be billed for charges not covered by your insurance company and payment is expected within thirty (30) days of receipt of our billing statement. Delinquent accounts may be placed with a collection agency. In the event that your unpaid balance is turned over to a collection agency for recovery, collection and attorney fees will be added to your balance. Returned checks will incur a \$30.00 service fee.

SIGNATURE

DATE