New Patient Form

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Name: _____ Sex: (M / F)
Last First Middle

Note to Medicare patients: Please print your name as it appears on you Medicare card.

Date of Birth: _____/_____/_____

Home Phone: _____Cell Phone: _____

Address: _____ Apt#: _____

City: _____State: _____ Zip: _____

Email Address: _____

Place of employment of Insured policyholder: _____

Private Pay/ No Insurance: _____

Primary Insurance Company: _____ID#: _____

Secondary Insurance Company: _____ID#: _____

Intel Employee -- (World Wide ID #): _____Last 4 digits of SS# of Insured: _____

Primary Care Physician: _____Phone: _____

PLEASE READ AND SIGN

I authorize release of information necessary to process any claims for services received in this office. I further authorize payment for any claims to be made to this office. By signing below you agree that you are financially responsible for co-pays, deductibles, and fees not paid for by insurance.

OFFICE PAYMENT POLICY

A. Payment on deductibles, co-payments, and non-covered charges are due at the time of service.
B. We accept cash, checks, debit cards, Visa, Mastercard, American Express, Discover, flex spending and HSA.
C. All balances are subject to a 1.5% charge or $3.00/month, whichever is greater.

Patient's Signature: _____Date: _____
Circle one: (Patient/ Parent/ Guardian)