

NEW PATIENT INFORMATION RECORD

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ APT # \_\_\_\_\_

\_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DRIVERS LICENSE # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MARITAL STATUS (CIRCLE ONE) S M W D

SPOUSE'S NAME OR PARENT'S NAME (if a minor child) \_\_\_\_\_ SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SPOUSE'S/PARENT'S EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF NEAREST RELATIVE (not living at your address) \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

WHAT PHYSICIAN REFERRED YOU TO US? \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? Newspaper \_\_\_\_\_ Phone Book \_\_\_\_\_ Billboard \_\_\_\_\_ Website \_\_\_\_\_ Radio \_\_\_\_\_ TV \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_



INSURANCE INFORMATION (please check all that apply & fill in the name and complete address)

( ) \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

( ) \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

( ) MEDICARE # \_\_\_\_\_

( ) MEDICAID # \_\_\_\_\_

IF HMO OR PPO, WHO IS YOUR "PRIMARY CARE PHYSICIAN?" \_\_\_\_\_ PHONE # \_\_\_\_\_ PLEASE BE SURE TO GIVE THE RECEPTIONIST YOUR INSURANCE CARD SO THAT WE MAY MAINTAIN A COPY IN YOUR FILE

EXPLANATION OF PRACTICE POLICY

Patients who carry any form of medical or surgical insurance should know that all services furnished are charged directly to the patient and that he or she is responsible for payment.

We will help prepare your primary forms to assist in the making of collections from your insurance company for hospital surgical services. However, WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT YOUR CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. This is a contract between you and/or your employer and the insurance company. YOUR BILL WITH US IS YOUR RESPONSIBILITY.

All insurance forms processed by this office and any proceeds there from, prior to payment in full, are assigned to this practice and I authorize payment of medical and surgical benefits directly to Christa Johnson Mars, M. D. or Cynthia M. Jones, M.D.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS ON MY BEHALF OR AS NECESSARY TO FACILITATE MY CARE. I AGREE TO BE FULLY RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF OR MY MINOR CHILD FOR SERVICES RECEIVED FROM CHRISTA JOHNSON MARS, M.D. or CYNTHIA M. JONES, M.D., WHETHER THOSE SERVICES ARE COVERED BY INSURANCE OR NOT.

PATIENT'S SIGNATURE / DATE

RESPONSIBLE PARTY'S SIGNATURE / DATE