



NEW ADULT PATIENT INFORMATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DOB: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**ADVANCE DIRECTIVE/LIVING WILL-**

Please bring to appointment if you have one. If not, please be sure to ask for information on the Advance Directive/Living Will.

SEX: MALE FEMALE MARITAL STATUS: S M D W HOME TELEPHONE ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ SS#: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER TELEPHONE: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ CARDHOLDER: \_\_\_\_\_

MEDICARE #: \_\_\_\_\_ MEDICAID #: \_\_\_\_\_

GROUP #: \_\_\_\_\_ CO-PAY: \$ \_\_\_\_\_

CONTRACT #: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

**SPOUSE INFORMATION:**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER TELEPHONE: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

GROUP #: \_\_\_\_\_ COPAY: \_\_\_\_\_ CONTRACT #: \_\_\_\_\_

**EMERGENCY INFORMATION:**

CONTACT PERSON: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**PLEASE READ AND SIGN BELOW: I acknowledge that all the information given is correct. I accept responsibility for any charges incurred by myself or a family member while on my account. I am aware that fees for services are expected at time of service and that a monthly re-bill of \$5.00 is charged on unpaid accounts.**

Signature \_\_\_\_\_

Date \_\_\_\_\_