

# WHAT'S NEW

## PATIENT INFORMATION

Today's Date: \_\_\_/\_\_\_/\_\_\_ File # \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First M.I.

Mailing Address: \_\_\_\_\_  
(  Unchanged)

City State Zip

Home Phone #: ( \_\_\_ ) \_\_\_\_\_

Office phone # Ext. Cell Phone #

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_  
(  Unchanged)

Employers Address: \_\_\_\_\_

City State Zip

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_  
(  Unchanged)

Spouse's Name: \_\_\_\_\_

## INSURANCE INFORMATION

Has any of your Insurance Information changed?  No  Yes  
If your insurance info has not changed, please continue on to block 3

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip  
Phone #: ( \_\_\_ ) \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please provide any new Primary/Secondary Ins. cards with this form.

## MEDICAL INFORMATION

What Medications are you taking? (Please include over-the-counter drugs) \_\_\_\_\_

Please list any new allergies, diseases, medical conditions, or procedures: include dates when possible: \_\_\_\_\_

In event of an emergency, whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_ Phone #: ( \_\_\_ ) \_\_\_\_\_ Cell #: ( \_\_\_ ) \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ Phone #: ( \_\_\_ ) \_\_\_\_\_

Has our office/staff met or surpassed your expectation of treatment?  Yes  No  Somewhat

Comments: (if any) \_\_\_\_\_

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_