

## **New Patient Form**

T: 919.383.1205 F: 919.383.2838

Patient Information     Last Name   First   Middle     Address   Unit #     City   State   Zip     Phone #'s   Home ()   Work ()   Cell ()     Emergency Contact Name   Relationship     Name   Relationship     Phone #'s   Home ()   Work ()   Cell ()     Responsible Party (If different then above)   Last Name   Middle     Last Name   First   Middle     Address   Unit #   City     City   State   Zip     Phone #'s   Home ()   Work ()   Cell ()     Date of Birth / /   Relationship   Emeil     Phone #'s   Home ()   Work ()   Cell ()     Date of Birth / /   Relationship   Email     Primary Insurance   Email   Primary Insurance     Insurance Company   DOB / /   Relationship     Policy#   Group#   Effective Date / /     Policy#   ODB / /   Relationship     Policy#   Group#   Effective Date / /     Policy#   DOB / /	DATE: / /	Patient #		
Address   Unit #     City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Email	Patient Information			
City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Email	Last Name	First	Middle	
Phone #'s     Home ( )     Work ( )     Cell ( )       Email	Address		Unit #	
Email   /   Age   Sex: (circle one)   M   F   Marital Status     Date of Birth   /   /   Age   Sex: (circle one)   M   F   Marital Status     Emergency Contact Name   Relationship   Relationship     Name   Relationship     Phone #'s   Home ( )   Work ( )   Cell ( )     Responsible Party (If different then above)   Last Name   First   Middle     Address   Unit #   City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )   Delematication     Date of Birth   /   Relationship   Email   Employer     Primary Insurance   Insurance Company   Phone ( )   Subscriber   DOB / /   Relationship     Policy#   Group#   Effective Date / /   /   Employer   Insurance Company   Phone ( )     Secondary Insurance   Insurance   Phone ( )   Subscriber   DOB / /   Relationship				
Date of Birth   /   Age   Sex: (circle one)   M   F   Marital Status     Emergency Contact Name     Name   Relationship     Phone #'s   Home ( )   Work ( )   Cell ( )     Responsible Party (If different then above)   Last Name   First   Middle     Address   Unit #   City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )   Out #     Date of Birth   /   Relationship   Email     Primary Insurance   Email   Phone ( )   Subscriber   DOB / /   Relationship     Policy#   Group#   Phone ( )   Effective Date / /   /     Secondary Insurance   Phone ( )   Subscriber   Phone ( )   Subscriber     Insurance Company   Phone ( )   Phone ( )   Subscriber   Phone ( )     Subscriber   DOB / /   Relationship   Phone ( )   Subscriber		Work ( )	Cell ( )	
Emergency Contact Name     Name   Relationship     Phone #'s   Home ( )   Work ( )   Cell ( )     Responsible Party (If different then above)     Last Name   First   Middle     Address   Unit #   City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )   Delta of Birth / /     Phone #'s   Home ( )   Work ( )   Cell ( )   Delta of Birth / /     Date of Birth / /   Relationship   Email   Primary Insurance     Insurance Company   DOB / /   Relationship   Effective Date / /     Policy#   Group#   Effective Date / /   /     Employer   Phone ( )   Secondary Insurance   Phone ( )     Subscriber   DOB / /   Relationship   Effective Date / /     Insurance Company   Phone ( )   Subscriber   Phone ( )				
Name   Relationship     Phone #'s   Home ( )   Work ( )   Cell ( )     Responsible Party (If different then above)   Middle     Last Name   First   Middle     Address   Unit #   City     Address   Unit #   City     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Cell ( )     Employer   Email   Email   Primary Insurance     Insurance Company   DOB / /   Relationship   Fifective Date / / /     Policy#   Group#   Effective Date / / /   /     Employer   Phone ( )   Phone ( )      Subscriber   DOB / / Relationship   Effective Date / / /     Insurance Company   Phone ( )       Secondary Insurance   Insurance   Phone ( )      Subscriber   DOB / / Relationship		Sex: (circle one) M F	Marital Status	
Phone #'s   Home ( )   Work ( )   Cell ( )     Responsible Party (If different then above)   Middle     Last Name   First   Middle     Address   Unit #     City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Email     Primary Insurance   DOB   /   Relationship     Insurance Company   DOB / /   Relationship   Effective Date / /     Policy#   Group#   Effective Date / /   /     Secondary Insurance   Phone ( )   Subscriber   DOB / /   Relationship     Insurance Company   DOB / /   Phone ( )       Secondary Insurance   DOB /   Relationship       Insurance Company   DOB /   Relationship       Subscriber   DOB /   Relationship				
Responsible Party (If different then above)     Last Name   First   Middle     Address   Unit #     City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Email     Primary Insurance   Email   Phone ( )     Subscriber   DOB / /   Relationship     Policy#   Group#   Effective Date / /     Employer   Phone ( )   Secondary Insurance     Insurance Company   Phone ( )   Phone ( )     Subscriber   DOB / /   Relationship     Insurance Company   Phone ( )   V     Secondary Insurance   Phone ( )   V     Subscriber   DOB / /   Relationship     Insurance Company   Phone ( )   V     Subscriber   DOB / /   Relationship				
Last Name   First   Middle     Address   Unit #     City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Email     Primary Insurance   Email   Phone ( )   Subscriber     Insurance Company   DOB / /   Relationship   Effective Date / /     Policy#   Group#   Effective Date / /   /     Employer   Phone ( )   Secondary Insurance   Phone ( )     Subscriber   DOB / /   Relationship   Effective Date / /     Insurance Company   Phone ( )   Phone ( )   Subscriber     Subscriber   DOB / /   Relationship   Effective Date /	Phone #'s Home()	Work ( )	Cell ( )	
Address   Unit #     City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Email     Employer   Email   Email   Insurance Company   Phone ( )     Subscriber   DOB / /   Relationship   Effective Date / /     Policy#   Group#   Effective Date / /   /     Employer   Phone ( )   Subscriber   DOB / /   Relationship     Subscriber   DOB /   Phone ( )   Subscriber   Insurance     Insurance Company   Phone ( )   Phone ( )   Subscriber   Phone ( )     Subscriber   DOB / /   Relationship   Subscriber   Insurance     Insurance Company   Phone ( )   Subscriber   Phone ( )   Subscriber	Responsible Party (If different then above)			
City   State   Zip     Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth   /   Relationship   Email     Employer   Email   Phone ( )   Subscriber   Phone ( )     Insurance Company   DOB / /   Relationship   Effective Date / /     Subscriber   DOB / /   Relationship   Effective Date / /     Policy#   Group#   Effective Date / /     Insurance Company   Phone ( )   Secondary Insurance     Insurance Company   DOB / /   Relationship     Secondary Insurance   Phone ( )   Subscriber	Last Name	First	Middle	
Phone #'s   Home ( )   Work ( )   Cell ( )     Date of Birth / /   Relationship       Employer   Email       Primary Insurance   Phone ( )       Insurance Company   DOB / /   Relationship      Subscriber   DOB / /   Relationship      Policy#   Group#   Effective Date / /      Employer   Phone ( )       Secondary Insurance   Phone ( )       Insurance Company   Phone ( )       Subscriber   DOB / /   Relationship	Address		Unit #	
Date of Birth   /   /   Relationship     Employer   Email     Primary Insurance     Insurance Company   Phone ( )     Subscriber   DOB / /   Relationship     Policy#   Group#   Effective Date / /     Employer   Phone ( )      Secondary Insurance   Phone ( )      Insurance Company   Phone ( )      Secondary Insurance   Phone ( )      Insurance Company   Phone ( )		State	Zip	
Employer   Email     Primary Insurance   Phone ( )     Insurance Company   DOB / / Relationship     Subscriber   DOB / / Relationship     Policy#   Group#     Employer   Phone ( )     Secondary Insurance   Phone ( )     Insurance Company   Phone ( )     Subscriber   DOB / / Relationship		- / /	Cell ( )	
Primary Insurance   Phone ( )     Insurance Company   DOB / / /   Relationship     Subscriber   DOB / / /   Relationship     Policy#   Group#   Effective Date / /     Employer   Phone ( )   /     Secondary Insurance   Phone ( )   /     Insurance Company   DOB / / /   Relationship     Subscriber   DOB / / /   Relationship	Date of Birth / /			
Insurance Company   Phone ( )     Subscriber   DOB / / /   Relationship     Policy#   Group#   Effective Date / /     Employer   Phone ( )   /     Secondary Insurance   Phone ( )   /     Insurance Company   DOB / / /   Phone ( )     Subscriber   DOB / / /   Relationship	Employer	Email		
Subscriber   DOB /   /   Relationship     Policy#   Group#   Effective Date /   /     Employer   Phone ( )    /     Secondary Insurance   Phone ( )   /   /     Insurance Company   Phone ( )    /     Subscriber   DOB /   /   Relationship   /	Primary Insurance			
Policy#   Group#   Effective Date   /     Employer   Phone ( )   /     Secondary Insurance   Phone ( )   /     Insurance Company   Phone ( )   /     Subscriber   DOB / /   Relationship	Insurance Company	Phone (	)	
Employer   Phone ( )     Secondary Insurance   Phone ( )     Insurance Company   Phone ( )     Subscriber   DOB / /   Relationship	Subscriber	DOB / / Relationshi	р	
Secondary Insurance   Phone ( )     Insurance Company   DOB / /   Relationship	Policy#	Group#	Effective Date / /	
Insurance Company Phone ( )   Subscriber DOB / / Relationship	Employer	Phone (	)	
Subscriber DOB / / Relationship	Secondary Insurance			
Subscriber DOB / / Relationship	Insurance Company	Phone (	)	
Policy# Group# Effective Data / /		DOB / / Relationshi	p	
	Policy#	Group#	Effective Date / /	
Employer Phone ( )	Employer	Phone (	)	
Referring Physician				
Name Clinic / Hospital	Name	Clinic / Hospital		
Address Phone ( )	Address		)	

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize *The Anaplastology Clinic* to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

## (Information pertains to *Medicare Patient Only*)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *The Anaplastology Clinic* for any services provided to me by *The Anaplastology Clinic*. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.