NEW PATIENT INFORMATION

Date _____ Email Address _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Wk Phone _____ Cell Phone _____

Marital Status _____ Sex M F Name of Spouse _____

SS# _____ Age _____ DOB _____

Employer _____ Occupation _____

Business Address _____

Business Phone _____

Insurance Company _____ ID# _____

Policy Holder _____ Group # _____

Policy holder SS# _____ DOB _____

Employer _____ Occupation _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. IF YOU ARE COVERED BY AN HMO/PPO PLAN, IT IS YOUR RESPONSIBILITY AS THE INSURED/PATIENT TO SEEK PROFESSIONAL CARE WITH A PARTICIPATING PROVIDER WITHIN YOUR PLAN. THE PATIENT (OR GUARDIAN) IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I HEREBY GIVE THE PHYSICIANS OF UNITY HEALTH NETWORK PERMISSION TO TREAT MYSELF OR MY DEPENDENT(S), AND I AUTHORIZE UNITY HEALTH NETWORK TO FURNISH ANY MEDICAL INFORMATION NECESSARY FOR INSURANCE CLAIM SUBMISSION AND/OR PAYMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY REMAINING FEES NOT COVERED BY INSURANCE.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIANS OF UNITY HEALTH NETWORK FOR SERVICES DESCRIBED HEREIN. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED.

Patient Signature _____ Date _____

Guarantor's Signature _____ Date _____

NEW PATIENT INFORMATION CONTINUED

**In case of emergency, whom should we notify? _____

Phone _____ 2nd Phone _____

May we discuss your medical information with any member of your family? _____No _____ Yes

If yes, please list the name(s) of person (s) you authorize to receive information regarding your condition

_____

_____

_____

_____

_____

_____

On occasion, we may need to call your home to leave information regarding results of any treatments or tests performed. If you have an answering machine at home, may we leave any information on your answering machine?

_____ Yes _____ No

Pharmacy Name _____

Phone _____