

NEW PATIENT INFORMATION FORM

PERSONAL INFORMATION (please print)

PATIENT NAME: _____ **M/F** _____ **BIRTH DATE:** _____

HOME ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP CODE:** _____

HOME PHONE: _____ **SOCIAL SECURITY:** _____

MARITAL STATUS: SINGLE _____ **MARRIED** _____ **WIDOWED** _____ **DIVORCED** _____

CHILDREN(S) NAMES AND AGES: _____

RESPONSIBLE BILLING PARTY NAME: _____

ADDRESS (if different from above): _____

EMERGENCY CONTACT (name and number): _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMPLOYMENT HISTORY (please print)

Are you employed? **Yes** **No** **Retired**

Current Employer: _____ **Occupation:** _____

Address: _____ **Phone Number:** _____

INSURANCE

Primary Insurance _____ **Policy #** _____ **Group #** _____

Secondary Insurance: _____ **Policy#** _____ **Group#** _____

TREATMENT AND PAYMENT AGREEMENT:

I authorize examination and treatment for this and all following physician visits.
I authorize payment and assignment of insurance benefits to Dr Nora Gindi.
I understand and I am personally responsible for ALL charges and deductibles.
I am personally responsible for supplying accurate and current insurance information.
I authorize a photocopy of this statement to serve as an original.

PLEASE TURN OVER AND COMPLETE THE BACK SIDE ≡ ≡