

**New Patient Information**

**Patient**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Name Of Employer: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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**Emergency**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**\*\*\*Does Family Practice Partners have permission to discuss your care with the above listed contact in an emergency situation? YES or NO**

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**Insurance**

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Telephone: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Telephone: \_\_\_\_\_ Group #: \_\_\_\_\_

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**Insurance Authorization and Assignment**

- 1) I authorize Family Practice Partners, LLC to release to my insurance carriers any information requested concerning my examination or treatment, and I understand that I am responsible for any changes not covered by my insurance.
- 2) I hereby authorize payment directly to Family Practice Partners, LLC for surgical and medical benefits payable for the services performed.
- 3) I authorize the administration of any anesthesia and analgesics that the doctor advises.
- 4) I understand that payment is expected at the time of service and that a reasonable fee may be added each month to accounts over 120 days old.
- 5) I authorize Family Practice Partners, LLC to contact me and/or leave a message at: Home  Work

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Printed Name of Guardian

\_\_\_\_\_  
Date

How did u hear about us? \_\_\_\_\_  
Referring Physician? \_\_\_\_\_

