

# WHAT'S NEW

## 1

### ABOUT YOU

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

Patient Name: \_\_\_\_\_  
LAST FIRST MI

Mailing Address: \_\_\_\_\_  
(  UNCHANGED )

CITY STATE ZIP

Home phone: ( \_\_\_\_\_ )  
( \_\_\_\_\_ ) OFFICE PHONE EXT. ( \_\_\_\_\_ ) CELL PHONE

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

Employer: \_\_\_\_\_  
(  UNCHANGED )

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

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

Marital Status: \_\_\_\_\_  
(  UNCHANGED )

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

## 2

### INSURANCE INFO

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 ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

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.

## 3

### MEDICAL INFO

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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_