

# New Patient Information Form

Date \_\_\_\_\_ To See Dr. \_\_\_\_\_  
 Name \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Marital Status S\_\_\_ M\_\_\_ W\_\_\_ D\_\_\_ Sep\_\_\_  
 Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_ Sex \_\_\_  
 Driver's License \_\_\_\_\_

\*\*\*\*\*

Employer \_\_\_\_\_  
 Employer's Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Supervisor \_\_\_\_\_

Spouse/Guarantor \_\_\_\_\_  
 Spouse/Guarantor/Employer \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security # \_\_\_\_\_

\*\*\*\*\*

Nearest Relative Not Living With You \_\_\_\_\_ Phone \_\_\_\_\_  
 Nearest Friend Not Living With You \_\_\_\_\_ Phone \_\_\_\_\_  
 Whom May We Contact In Case of an Emergency? \_\_\_\_\_ Phone \_\_\_\_\_  
 Whom May We Thank for Referring You to Us? \_\_\_\_\_ Phone \_\_\_\_\_  
 Who is Financially Responsible for Your Treatment? \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information – If we copied your card, you need not complete this section.

Medicare # \_\_\_\_\_  
 Primary Coverage \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Mail To: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Group/Policy # \_\_\_\_\_ ID#: \_\_\_\_\_  
 Do You Have Copay? Yes \_\_\_ No \_\_\_  
 If Yes What Amount? \_\_\_\_\_

Medicaid # \_\_\_\_\_  
 Secondary Coverage \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Mail To: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Group/Policy # \_\_\_\_\_ ID#: \_\_\_\_\_  
 Do You Have Copay? Yes \_\_\_ No \_\_\_  
 If Yes What Amount? \_\_\_\_\_

Please Note: If your insurance is a managed Care Plan, we must either have a claim form or a copy of your insurance card. If neither is received, the patient is responsible for full payment at the time of service. If you are not on a Managed Care Plan, we require full payment at the time of service and a document will be given to the patient for filing insurance. We will file Medicare and Medicaid. If you are a Medicaid recipient, you must be Doctor referred.

Authorization: I hereby irrevocably authorize ETGA to furnish necessary information to physicians, laboraories, insurance carriers or parties involved in my case. I also irrevocably assign to ETGA all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_