NEW PATIENT INFORMATION SHEET

Patient's Full Name:_____

Last First Middle

Address:_____

Phone Number: _____ _____ _____

Home Work Cell

Social Security #:_____ Date of Birth:_____/_____/_____ Age:_____

Name of person(s) to whom we may discuss your healthcare and/or your bill:

Name:_____ Relationship to you:_____

Check all that apply: ( )Single ( )Married ( )Widow(er) ( )Separated ( )Divorced

Gender: ( )Male ( )Female Preferred Language: _____

Check which apply:( )Hispanic/Latino ( )African American ( ) White ( ) Native American ( ) Asian/Pacific ( )Other

Patient's Employer:_____

Name of person responsible for this patient : _____

Relationship to Patient:_____ Responsible party's Social Security #:_____

Date of Birth:_____/_____/_____ *patients may be required to provide picture ID

Address:_____Phone: _____

Emergency Contact:_____Phone:_____Relationship:_____

INSURANCE

Primary Insurance

Name of Insurance:_____ Policy Number:_____

Insured's Name:_____ Insureds' DOB:_____

Secondary Insurance

Name of Insurance:_____ Policy Number:_____

Insured's Name:_____ Insureds' DOB:_____

How did you hear about us? ( )Doctor ( )Family/Friend ( )Internet ( )Newspaper ( )Other

Name of your primary care physician:_____

Reason for your visit today:_____

Authorization: I authorize payment of Medicare, BCBS, Medicaid or other insurance benefits be made directly to OEC on my behalf for treatment rendered to me by one of its physicians. I also authorize OEC to disclose my personal health information to any entity requiring this information for the purpose of treatment, payment and healthcare operations.

PATIENT SIGNATURE:_____ DATE:_____

RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____