

# NEW PATIENT INFORMATION

Please fill out completely

Last Name.....First Name.....M.I.....  
Date of Birth.....Gender.....SSN.....Marital Status.....  
Phone (H).....Phone (W).....Phone (Cell).....  
Address.....ZIP.....Driver's Lic #.....  
E-mail address.....Preferred Pharmacy (address/ph).....  
Occupation:.....Employer Name/Address.....ZIP.....

**EMERGENCY CONTACT NAME**.....Phone.....  
Address:.....ZIP.....Relation to patient.....

**HOW DID YOU HEAR OF US?**.....

**IF PATIENT IS MINOR, GIVE RESPONSIBLE PARTY NAME**.....

Date of birth.....Gender.....Phone (H).....Phone (W).....  
Marital Status.....SSN.....Driver's Lic #.....  
Address.....ZIP.....  
Employer Name and Address.....Zip.....

**PRIMARY INSURANCE INFORMATION** (Please give card to receptionist to copy)

INSURANCE NAME.....ID #.....GRP#.....  
Policy Holder Name.....Date of Birth.....  
SSN.....Patient relation to policy holder.....  
Address.....ZIP.....  
Phone (H).....Phone (W).....Phone (Cell).....  
Employer Name/Address.....ZIP.....

**SECONDARY INSURANCE INFORMATION** (Please give card to receptionist to copy)

INSURANCE NAME.....ID #.....GRP#.....  
Policy Holder Name.....Date of Birth.....  
SSN.....Patient relation to policy holder.....  
Address.....ZIP.....  
Phone (H).....Phone (W).....Phone (Cell).....  
Employer Name/Address.....ZIP.....

**AUTHORIZATION FOR TREATMENT/BENEFIT ASSIGNMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

I give my authorization for treatment and release of medical information to Dr. Dan Bautista and to my insurance companies to facilitate my claims. I authorize my insurance benefits to be paid directly to Dr. Dan Bautista, realizing **I am ultimately responsible for any and all portions of the charges not paid by my insurance plan(s) as allowed per contract with Dr. Bautista.** I hereby authorize Dr. Dan Bautista to release any medical or incidental information to other physicians or facilities that may be referred to by this office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF FINANCIAL POLICIES I acknowledge that I have read and understand and received a copy of the practice's Financial Policy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received this Practice's Notice of Privacy Practices and understand that my protected health information may be used by this Practice as described in the notice.

By signing, I have read, understood and accept the above.

PATIENT/LEGAL GUARDIANNAME.....

PATIENT SIGNATURE.....DATE.....