

**PATIENT INFORMATION SHEET (ADULT)**

PATIENT NAME: LAST		FIRST	MIDDLE INITIAL	DATE OF BIRTH:
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.				
HOME ADDRESS:				
CITY:	STATE:	ZIP CODE:	EMAIL:	
EMPLOYER:	OCCUPATION:		YEARS EMPLOYED:	
HOME PHONE:	BUS. PHONE:	CELL PHONE:		
DRIVER'S LICENSE:		SOC. SEC. NO:		
SEX: <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		REFERRED BY:	
SPOUSE'S NAME: LAST		FIRST	MIDDLE INITIAL	DATE OF BIRTH:
				SOC. SEC. NO:
SPOUSE'S EMPLOYER:		YEARS EMPLOYED:	BUS. PHONE:	
CHILDREN LIVING AT HOME: (names & birth dates)				
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:				PHONE:

**INSURANCE**

PRIMARY INSURANCE CARRIER NAME:		POLICY ID#:	GROUP #:
INSURED'S NAME: LAST		FIRST	MIDDLE INITIAL
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:		
SECONDARY INSURANCE CARRIER NAME:		POLICY ID #:	GROUP #:
INSURED'S NAME: LAST		FIRST	MIDDLE INITIAL
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:		

**PATIENT ELIGIBILITY WAIVER**

I HEREBY ATTEST THAT I AM AN ELIGIBLE MEMBER OF THE HEALTH PLAN NOTED ABOVE. I AGREE THAT SHOULD IT BE DETERMINED THAT I AM INELIGIBLE FOR SERVICES RENDERED BY NEWPORT FAMILY MEDICINE OR BY ANOTHER FACILITY OR PHYSICIAN AS THE RESULT OF A NEWPORT FAMILY MEDICINE PRIMARY CARE DIRECT REFERRAL, I WILL BE RESPONSIBLE FOR PAYMENT TO NEWPORT FAMILY MEDICINE OR ITS AGENT FOR THOSE SERVICES DEEMED INELIGIBLE OR NOT COVERED. I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN. I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME TO SECURE PAYMENT FROM MY INSURANCE COMPANIES.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**In order to control costs of billing we request charges for office visits and/or co-payments be paid at the conclusion of each visit.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_