

New Patient Information Form

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Gender: Male Female Other Social Security #: _____
Home address: _____
House number Street City State ZIP
Phone: _____(Preferred) _____(Secondary) Email: _____
Race: American Indian Asian Black/African American Caucasian Hispanic Decline
Marital Status: Married Single Divorced Separated
Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline
Occupation: _____ Employer: _____ Employer phone no: _____
Preferred Language: _____ Best way to contact you: _____
Preferred Pharmacy: _____ Pharmacy phone no: _____
Emergency contact name: _____ Relationship: _____ Phone: _____
How did you hear about us? _____

Responsible Party for this visit:

Last name: _____ First name: _____ MI _____
Relationship to patient: _____ DOB: _____ SS#: _____
Home address: _____
House number Street City State ZIP
Phone: _____(Preferred) _____(Secondary) Email: _____
Employer: _____ Employer phone: _____

Insurance Information

Primary Insurance: _____ ID#: _____
Subscriber name: _____ DOB: _____ SS#: _____
Relationship to patient: _____ Group#: _____

Secondary Insurance: _____ ID#: _____
Subscriber name: _____ DOB: _____ SS#: _____
Relationship to patient: _____ Group#: _____

I hereby certify that above information is true and correct to the best of my knowledge. I hereby authorize Bassi Clinic to release all medical information pertaining to my treatment, to my insurance company or other third parties, to obtain payment for the medical services. I understand that I am responsible for all charges regardless of insurance coverage. I hereby agree to pay for services rendered to the patient in the event that my insurance coverage does not pay. I understand that all balances not paid within 30 days of statement due date will accrue an interest charge in the amount of 1.5% per month/18% per annum. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services. I acknowledge that the photo IDs taken are used in patient recognition per HIPAA guidelines.

Patient Signature: _____ Date: _____