New Patient Form

Allman Family Medicine, PC

How did you hear about us? _____ **Email**_____

Patient Information

Patient's Name _____

Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ Cell Phone _____

Sex _____ Birth Date _____ Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____

mm/dd/yyyy

Patient's Employer _____ Occupation _____ Work Phone _____

Spouse's Name _____

Last Name First Name Middle Name Name goes by

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____

Pharmacy Information

Pharmacy Name _____

Location _____Phone _____Fax _____

Insurance Information

Insurance #1 _____

Group #_____ Contract # _____ Co-pay _____

Name of Insured _____Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

mm/dd/yyyy

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured_____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

mm/dd/yyyy

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Allman Family Medicine to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Allman Family Medicine or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____