

## NEW PATIENT INFORMATION

### Patient Information

Last Name	First Name	MI
Street Address		
Zip	City	State
Home Phone ( )	Wk ( )	Cell ( )
Maiden Name	DOB	Sex: M / F
SSN#		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		
Student (YES / NO)		<input type="checkbox"/> Full time <input type="checkbox"/> Part time
Employer		
Employer Address		
Driver's License Number	Referring Physician	Refer Physician Phone # ( )
Emergency Contact	Emergency Phone ( )	Relationship:

### Insurance Information

Primary Insurance Co.	Insurance#	Group#
Insured Name:		Insured Address
Insured Date of Birth:	Home Phone: ( )	Wk Phone: ( )
Sex: M / F		
Insured Employer	Relationship of Patient to insured	
Secondary Insurance Co.	Insurance#	Group#
Insured		Insured Address
Insured DOB:	Home Phone: ( )	Wk Phone: ( )
Sex: M / F		
Insured Employer	Relationship of Patient to insured	

### Responsible Party (fill out only if other than the patient)

Last Name:	First Name:	MI
Street Address		City
		State
		Zip
Relationship to patient:	DOB:	SS#
Sex: M / F		
Employer:	Work Phone: ( )	Home Phone: ( )

### Other Family Members that are Patients of Dr. Dilley & Gary Dunham, PA-C

Name	Relationship
Name	Relationship

**Signing This Form Indicates That All Charges Have Been Explained**

#### Payment Policy:

All Professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

#### Authorization of Payment:

I hereby authorize the provider of services to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to me for services rendered.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_