NEW PATIENT INFORMATION

Date_____

(please print)

Patient's Legal Name	**CALLED NAME:**	**Date of birth:**
Male/ Female (please circle)	**SSN: (required)**	**Marital Status: M W D S**
Street Address	City/State/Zip	**Home Phone**
		Cell Phone
Patient's/ Parent's Employer	Occupation	**Work Phone**
Employers Address	City/State/Zip	Email address:

Spouse or Parent's Name	SS#	Spouse Date of Birth
Spouse or Parent's Employer	Occupation	Business Phone
		Cell Phone
Employers Street Address	City/State/Zip	Email address:

Emergency Contact Name	**Emergency Contact Phone**	Drug Store Preference (name & phone #)
Referred by: **Dr.**_____	How did you hear about us? 1. phone book 5. family 2. sign 6. other 3. friend 4. ad	Have you or any immediate Family member been treated by Dr. Conner before? Name:_____

Person responsible for payment:	Street Address:	Home Phone #:
Primary insurance:	Policy Holder Name/ SSN/ DOB	Policy #
Secondary insurance:	Policy Holder Name/ SSN/ DOB	Policy #

Please read: **ALL CHARGES ARE DUE AT THE TIME OF SERVICE.** THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE. IT IS OUR POLICY THAT PROFESSIONAL SERVICES RENDERED IN THE OFFICE BE PAID AT THE TIME OF SERVICE. THERE WILL BE A 1.75% FINANCE CHARGE PER MONTH ON ACCOUNTS 90 DAYS PAST DUE. OUR OFFICE FILES INSURANCE FOR MOST PLANS INCLUDING BC/BS , CHAMPUS, MEDICARE AND MEDICAID. (IT IS THE PATIENT'S RESPONSIBILITY TO CHECK TO MAKE SURE OUR OFFICE PARTICIPATES IN YOUR NETWORK). CURRENTLY WE ARE NOT ACCEPTING NEW MEDICAID PATIENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE F. GEOFFERY CONNER, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature: _____ Date_____

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