# DR. JOHN M. YOUNG, M.D.

## NEW PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY) DATE_____

### PATIENT INFORMATION

| FIRST NAME | MI | LAST NAME | SEX | DATE OF BIRTH | AGE | SOCIAL SECURITY NO. |
|---|---|---|---|---|---|---|
| | | | M F | | | |

| STREET ADDRESS | ZIP CODE | CITY AND STATE | HOME PHONE NO. |
|---|---|---|---|
| | | | |

### PARENT INFORMATION **(INSURED)**

| FIRST NAME | MI | LAST NAME | STREET ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|---|---|---|
| | | | | | |

| DATE OF BIRTH | SOCIAL SECURITY NO. | MARITAL STATUS | DRIVER'S LICENSE# | HOME PHONE | CELL PHONE |
|---|---|---|---|---|---|
| | | S M W D SEP | | | |

EMERGENCY CONTACT (NOT LIVING IN THE SAME HOUSEHOLD) WITH A PHONE NUMBER AND **RELATIONSHIP** TO PATIENT AND ADDRESS

### EMPLOYER INFORMATION OF INSURED

| EMPLOYER | ADDRESS | ZIP CODE | PHONE NO. |
|---|---|---|---|
| | | | |

### INSURANCE INFORMATION - PLEASE COMPLETE ALL APPLICABLE INFORMATION

PRIMARY INSURANCE COMPANY:_____ ID/GROUP:_____

COMPLETE ADDRESS:_____ PHONE NO:_____

POLICY HOLDER NAME:_____ POLICY HOLDER D.O.B._____ CO-PAY:_____

POLICY HOLDER ADDRESS:_____ PHONE NO.:_____

PARENTS NAME:_____ PHONE NO.:_____

ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____

PHARMACY

_____

SIBLINGS

1._____ DOB_____

2._____ DOB_____

3._____ DOB_____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

I request that payment of authorized Medicare / Other Insurance company benefits be made either to me or on my behalf to **JOHN M. YOUNG, M.D.** for any service furnished me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases. the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

SIGNATURE_____ DATE_____