New Patient Form

PATIENT INFORMATION

PATIENT'S NAME: ______________________ ______________________ SSN: _________________________
First Last

ADDRESS: ____
St Apt. # City State Zip code

BIRTHDATE: _______ /_______ /________ HOME PHONE: ( ) - .

EMAIL: ____ MOBILE PHONE: ( ) - .

LEGAL SEX: M ☐ / F ☐ Preferred Language: _________________ MARITAL STATUS __________________________

Preferred method of contact: Phone ☐ Email ☐ Text ☐

How did you hear about us? Advertising ☐ Physician's referral ☐ Hospital ☐

Word of Mouth ☐ Patient in the practice ☐ Other (please specify)
____

INSURANCE INFORMATION

If you are paying out of pocket, please initial _________and skip this section.

Primary Insurance :_______________________________ Member ID:______________________________

Group Number: ___________________ **If you are not the Policy Holder, please fill out the following:**

Relationship to Policy Holder: ___________ Policy Holder's Name: ____
First Last

Policy Holder's Birthdate: ___ /____ /_____

Do you have secondary insurance? Yes ____ No _____

Secondary Insurance : _____________________________ Member ID: ____________________________

Group Number: ___________________ **If you are not the Policy Holder, please fill out the following:**

Relationship to Policy Holder: ___________ Policy Holder's Name: ____
First Last

Policy Holder's Birthdate: _____ /_____ /_____

Patient/Guardian Signature	***Date***: _____ /_____ /_____

New Patient Form

In Case of Emergency

Name of Contact:____
First Last

Relationship to Patient: ___________________________ Phone: (______) ________-____________.

FINANCIAL POLICY AGREEMENT For the full financial policy please visit http://swanprimarycare.com

I understand that payment for services is expected at the time of my visit. This includes co-pays, balances from prior visit, and payment in full if SWAN Primary Care, PLLC is not contracted with my insurance carrier, or if I do not have insurance coverage. **I agree that I will be financially responsible for any non-covered services.** I authorize my insurer to pay any benefits directly to SWAN Primary Care, PLLC. I understand that SWAN Primary Care, PLLC will charge me **$25 for any missed appointments ($50 for missed procedures**) that are not canceled at least 24 hours in advance. I understand that there is a $50 service charge on all returned checks. I understand that for any outstanding balance that remains unpaid, the account may be turned over to a collection agency.

I have read and understood the office policies and procedures of SWAN Primary Care.

NAME:____

SIGNATURE:____ **DATE**: _______ /_______ /________

Privacy Acknowledgement/ HIPAA For the full policy please visit: http://swanprimarycare.com

We are required by law to provide you, at your request, with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. The full policy can be found at the website above or provided to you by our receptionist upon your request. Please sign this form to acknowledge the offer of the Notice.

NAME:____

SIGNATURE:____ **DATE**: _______ /_______ /________