NEW PATIENT INFORMATION

Name (First, M.I., Last)				**DOB**			
Social Security#				**Age**		**Sex**	M / F
Address:		City, State, Zip					
Home Phone#		Cell #		Work #			
Primary Language Spoken: Secondary Language Spoken:	Ethnicity: (circle one) Hispanic or Latino **OR** **Not** Hispanic or Latino	Race: (please circle one) White ● American Indian or Alaskan ● Native Asian ● African American ● Native Hawaiian or other Pacific Islander					
Married / Single / Other	Email address:						
How would you prefer our office to contact you?	via email / via phone (circle one)						
May we leave a message on your voicemail pertaining to your medical information?	YES / NO						
□ Above Demographics Information Provided on Face Sheet							
Responsible Party		Relationship					
Employer & Occupation							
How were you referred to us? Hospital/ Physician/ Friend or Patient/Other (list) →							
In case of an emergency, who should we notify?		Realtionship					
Address:		Phone #					
PCP (First & Last Name)		PCP City					
I give permission for CliniCare to discuss my information with the following person							
Name		Relationship					

PRIMARY INSURANCE			
Insurance Company	*	HMO PPO POS Indemnity (circle one)	
Insured's Name	*	Insured's Employer	*
Insured's DOB	/ /	Insured's Social Security #	
Claim's Mailing Address			
Insurance Telephone #		Policy #	
SECONDARY INSURANCE			
Insurance Company	*	HMO PPO POS Indemnity (circle one)	
Insured's Name		Insured's Employer	
Insured's DOB	/ /	Insured's Social Security #	
Claim's Mailing Address			
Insurance Telephone #		Policy #	

Copays, deductibles and any other patient responsibility fees are due when services are rendered.
If you have any questions about fees, please check with us prior to being seen.
I understand that insurance will be filed by your office as a courtesy and does not constitute a contract between the physician and insurance company for payment of your services.

⇨ _____ _____

Patient Signature/Authorized Guardian Date