

NEW PATIENT INFORMATION

Please print neatly. Thank you.

Patient's Name: _____

Parent/Caregiver Name: _____

Phone: (home) _____ (work) _____ (cell) _____

Which would be best way to get a hold of you: home work cell

Patient's Date of Birth: ____/____/____ Age: _____ Gender: M F

Street Address: _____ City: _____ State: _____ Zip: _____

If different than above:

Mailing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact _____ Phone _____

Do you authorize release of your medical information to anyone other than yourself? Yes ___ No ___

If Yes, whom? _____ **Relationship** _____

CONSULT REQUESTED BY (Referring Physician) _____

Primary Insurance: _____ Policyholder Name: _____

Policyholder ID#: _____ Date of Birth: ____/____/____

Secondary Insurance: _____ Policyholder Name: _____

Policyholder ID#: _____ Date of Birth: ____/____/____

IMPORTANT: All charges are due at the time of the office visit. If surgery is indicated, **the patient/parent is responsible for furnishing a copy of the insurance card to the office prior to scheduling surgery.** All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage, unless arrangements have been pre-approved by the Office Manager. I hereby authorize Jack D. Sedwick, MD to furnish all information to insurance carriers concerning my illness and treatments, and I hereby authorize Dr. Sedwick all payments for medical services rendered to myself or my dependants.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(located on office front counter for review – copy available upon request.)

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices.

Date _____ Signature _____