New Patient Information

Please print neatly and complete all entries:

Today's Date	**Office Location**	**Reason for Visit**
Patient Name (Last, First, MI)	**Social Security Number**	**Date of Birth**
Insured's Name (Last, First, MI)	**Social Security Number**	**Date of Birth**
Home Address (Street, City, State, Zip)	**Home Phone**	**Alternate Phone (Work or Cell)**
Nearest Relative (Spouse, Child, Parent, etc.)	**Home Phone**	**Alternate Phone (Work or Cell)**
Nearest Relative not living with you	**Home Phone**	**Alternate Phone (Work or Cell)**
How will we be paid today?	**Email Address**	**Referred to our office by:**
Primary Care Physician / Date last seen	**Shoe Size / Height / Weight**	**Is this an accident or injury? Yes No** **Did it occur at work? Yes No**
Do you have or are you being treated for: (Please circle) Diabetes Drug Reactions Asthma Arthritis HIV / AIDS Heart Disease Anemia High Blood Pressure Stomach / Intestinal Disorders	**Are you allergic to: (please circle)** Penicillin Local Anesthetic Iodine Adehesive Tape Codeine Sulfa Drugs Aspirin Other:____________	**Please list any medications you are taking or attach a separate list:**
Significant Illness / Injury in the past 5 years:	**Insurance Company / Provider Including Claims Mailing Address:**	**Patient ID** **Group Number**
Is this an HMO?	**Are you required to have a referral?**	**Is this a percentage plan?**

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Scott Burdge, P.A., for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions to certify that the information provided here is true and correct.

Signed: ____

Acknowledgment of Receipt of Privacy Notice

I ________________________ Acknowledge that I have received/read the Privacy Notice for Dr. Scott Burdge.

Signed:________________________________ Date:__________________