

## NEW PATIENT INFORMATION RECORD

### PATIENT INFORMATION (Please Print)

PATIENT'S NAME	SEX	M	F	MARITAL STATUS	S	M	W	O	SEP	DATE OF BIRTH	AGE	HOME PHONE
REASON FOR VISIT											SSN OF PATIENT	
STREET ADDRESS								CITY AND STATE			ZIP CODE	
PATIENT'S EMPLOYER						OCCUPATION (INDICATE IF STUDENT)				BUSINESS TEL NO.		
EMPLOYER'S STREET ADDRESS								CITY AND STATE			ZIP CODE	
SPOUSE'S NAME												
SPOUSE'S EMPLOYER						EMPLOYER'S ADDRESS				BUSINESS TEL NO.		
NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU												
FAMILY PHYSICIAN								REFERRING PHYSICIAN				

### IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP							HOME TEL NO.				
MOTHER'S EMPLOYER						OCCUPATION				BUSINESS TEL NO.		
EMPLOYER'S STREET ADDRESS								CITY AND STATE			ZIP CODE	
FATHER'S NAME			STREET ADDRESS, CITY, STATE AND ZIP							HOME TEL NO.		
FATHER'S EMPLOYER						OCCUPATION				BUSINESS TEL NO.		
EMPLOYER'S STREET ADDRESS								CITY AND STATE			ZIP CODE	

### INSURANCE INFORMATION

NAME OF INSURANCE COMPANY				POLICY NUMBER			INDIVIDUAL OR GROUP?	
POLICY HOLDER'S NAME			How long have you had this insurance?		SSN OF POLICY HOLDER		IF GROUP, NAME OF EMPLOYER	
MAILING ADDRESS FOR INSURANCE CLAIMS								
OTHER INSURANCE POLICIES								

I authorize release of any medical information and payment of medical benefits to Dr Widick.  
 I understand that even though I have some type of insurance coverage, I am responsible for payment of service.  
 I authorize release of my medical records to other health care professionals involved in my care.

Preferred Payment: Cash / Check / Credit Card      Signature \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE; PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. IF YOU ARE UNABLE TO PAY OR MEET THE CONDITIONS OF YOUR INSURANCE PLAN, ASK TO SPEAK WITH THE FRONT DESK. SEE FINANCIAL POLICY / AGREEMENT REGARDING FILING INSURANCE CLAIMS, COLLECTING CO-PAYS, DEDUCTIBLES AND AUTHORIZATIONS.**