**New Patient Application**

\*Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*DOB:\_\_\_\_\_\_\_\_\_\_\_ \*SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Primary Insurance Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Eligibility/Claim Phone Number (on back of Card):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copay:\_\_\_\_\_\_\_\_ Coinsurance:\_\_\_\_\_\_\_\_\_ Out of Pocket:I:\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_ F:\_\_\_\_\_\_\_ Met: \_\_\_\_\_\_\_

Family Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lifetime max:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spoke with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on: \_\_\_\_\_\_\_\_\_\_ Reference #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Secondary Insurance Co:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Eligibility/Claim Phone Number (on back of Card):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copay:\_\_\_\_\_\_\_\_ Coinsurance:\_\_\_\_\_\_\_\_\_ Out of Pocket:I:\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_ F:\_\_\_\_\_\_\_ Met: \_\_\_\_\_\_\_

Family Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lifetime max:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spoke with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on: \_\_\_\_\_\_\_\_\_ Reference #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Previous Physicians/Facilities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Previous Diagnosis/Chronic Illness (such as diabetes, blood pressure, surgeries):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins.Verified:\_\_\_\_\_ PMP:\_\_\_\_\_ ODCR: \_\_\_\_\_ \*Referred by (Family that are patients): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPROVED / DENIED

(PLEASE CIRCLE ONE)

*\*PLEASE FILL OUT ANY HIGHLIGHTED PORTION* ***ONLY*** *AND RETURN TO THE OFFICE\**