



New Patient Consent Forms

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date _____

Information on patient

Name _____

Last name First name MI

Nickname _____ Sex: Male Female

Home address _____

City _____ State _____ ZIP _____

Home phone _____ Cell Phone _____ Work phone _____

E-mail Address _____

Date of birth _____ SS # _____

Occupation _____ Primary Care Physician _____

Referred by _____ Relationship to referring person _____

Employer Information

Employer: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

Spouse Information

Spouse's Name: _____ SS#: _____

Spouse's Employer: _____ Telephone: _____

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

Information on party responsible for payment

Check here if this information is the same as in the box above.

Name of Guarantor (printed): _____

Home address _____

City _____ State _____ ZIP _____

Home phone _____ Work phone _____

Date of birth _____ SS # _____

Employer _____

Relationship to patient _____

Initials _____

Patient's Name: _____

INSURANCE INFORMATION

Primary Insurance

Company Name: _____ Policy #: _____

Mailing Address: _____ Group #: _____

_____ Co-Pay: _____

Effective Date: _____

Please complete the following even if you have provided your insurance card

Subscriber's Name: _____ Sex: _____ D.O.B.: _____ Employer: _____

Subscriber's Relationship to Patient: Self Spouse Child Parent

Primary Care Physician Assigned to You: _____

Secondary Insurance

Company Name: _____ Policy #: _____

Mailing Address: _____ Group #: _____

_____ Co-Pay: _____

Subscriber's Name: _____ Sex: _____ D.O.B.: _____ Employer: _____

Subscriber's Relationship to Patient: Self Spouse Child Parent

NOTIFY IN CASE OF EMERGENCY (Next of kin outside the home)

Name	Relationship	Phone Number

How did you hear about our clinic? _____

I agree to be responsible for any charges for services and materials supplied by **NuStart** and its staff for the above patient.

Signature of party responsible for payment

Date