PATIENT CONTACT INFORMATION Please Print/Complete All Sections

Patient Name:_____ Sex: M F
First Last MI

Home Address:_____ Apt.#_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Email:_____

Date of Birth:_____ Social Security#_____ Marital Status: M S W D

Driver's License# and State:_____

Insurance Information

Cardholder's Name:_____Cardholder's DOB:_____
Cardholder's Soc. Sec.#_____ Employer:_____
Employer Address:_____
City:_____State:_____Zip:_____
Relationship to Patient:_____ Full time___ Part time___ Retired___ Student_____

Emergency Contact-Other than someone in your own household

Name:_____Relationship:_____Phone#_____

I will be paying all fees today by: Check____ Cash____ Credit Card____ for any co-pays, Deductibles and/or non-covered services performed.
Who referred you to this office?_____

New Horizons Medical Center, P.C. will bill your insurance company for services covered under your policy. All insurance policies have exclusions, limitations and maximums and most policies have deductibles and co-payments/co-insurance that may apply to your services. **It is the responsibility of the patient to know and understand his/her individual insurance coverage.** Payment is required **AT THE TIME OF SERVICE** for any co-pays/deductibles and non-covered services that are not payable by your insurance company. Signing below authorizes New Horizons Medical Center, P.C. and the staff/laboratory to bill your insurance company for their services covered under your policy and to release my medical records to third party payers responsible for payment, such information from your medical record as is required in order to receive reimbursement for a billing rendered related to your treatment.

I understand that that I will be responsible for any co-pays, deductibles and/or non-covered services performed on my behalf at New Horizons Medical Center, P.C. at the time of service. Prior to scheduled appointments, I will be requested to pay any past balances, if any. **Patients agree to an annual physical exam** as a condition of being a patient at New Horizons Medical Center, P.C. as this best allows the physician and staff to manage or detect current illnesses and provide adequately for appropriate health maintenance.

Signature of Responsible Party:_____ Date:_____