NEW PATIENT INFORMATION
Shiloh Pain and Primary Care

First Name: _____ Last Name: _____

Date of Birth: ____/_____/_____ Gender: ❑ Male ❑ Female ❑ Other_____

Cell #: _____ Home Phone #: _____

Home Address: _____ City _____ State _____ Zip _____

E-Mail: _____ Soc. Security #: _____

Preferred appointment reminder: ❑ Phone (voice) ❑ Phone (text) ❑ None

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Race: ❑ White ❑ African American ❑ Latin American ❑ Other _____

Occupation: _____ Employer: _____

Pharmacy: *Name* _____ *Address:* _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Care Physician: _____ *Phone:* _____

Are you required to use a specific Lab? Yes / No (LabCorp, Quest, Etc…) Name: _____

Sign-up for Telemedicine ❑ Yes, If yes enter cell phone # & email address ❑ No

Cell Phone #: _____ Email Address: _____

ACCIDENT INFO: Did you have an accident or injury? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work

*****INSURANCE INFO:*** Do you have health insurance? ❑ Yes ❑ No Secondary insurance? ❑ Yes ❑ No

***If yes, Subscriber's Name:* _____ *Relation:* _____

Subscriber's DOB: _____ *Subscriber's Employer:* _____

ASSIGNMENT OF BENEFITS & RELEASE (FOR INSURANCE PATIENTS ONLY)

I certify that I (or my dependent) have insurance coverage with following insurance companies:

Primary: _____

Secondary / Supplemental: _____

and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE: _____ DATE: _____