Stillwater Primary Care

NEW PATIENT INFORMATION

Welcome to Stillwater Primary Care
Please provide the following information.

PATIENT INFORMATION

First Name | MI | Last Name | Gender Identity

Street Address (Road or Street) | City, State, Zip Code

Home Phone ( ) | Cell Phone ( ) | Email

Birthdate (MM-DD-YYYY) | SSN | Race | Ethnicity

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Relation to Insured ☐ Child ☐ Self ☐ Spouse ☐ Other

Employment: ☐ Part-time ☐ Full-time ☐ Retired ☐ None

Studen ☐ Part-time ☐ Full-time ☐ None

Employer or School Name | Street Address (Road or Street)

Zip Code | City | State | Business Phone

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name | MI | Last Name

Street Address (Road or Street) | City, State, Zip Code

Home Phone) | SSN | Sex (M/F) | Birthdate (MM-DD-YYYY)

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Relation to Ins: ☐ Child ☐ Self ☐ Spouse ☐ Other

Employment: ☐ Part-time ☐ Full-time ☐ Retired ☐ None

Student ☐ Part-time ☐ Full-time ☐ None

Employer or School Name | Birthdate (MM-DD-YYYY)

Street Address (Road or Street) | City, State, Zip Code

Primary Ins. Company

Phone # | Policy # | Group # | Exp. Date

Secondary Ins. Co

Phone # | Policy # | Group # | Exp. Date

By signing this form, I authorize the following:

(a) the release of any medical or other information necessary to process insurance claims

(bl payment of medical benefits directly to this practice for services rendered

Signature _____ Date _____

HOW DID YOU HEAR ABOUT US ?

IN CASE OF AN EMERGENCY,
WHOM SHOULD WE CONTACT?

Name

Address

City

State Zip Code

Daytime Phone #

Evening Phone #

Other Phone #

Relationship

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR FEES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the Stillwater Primary Care shall be entitled to reasonable attorney's fees and collection costs.

By submitting this patient information form, you are agreeing to the following:

- That payment of authorized benefits will be made on your behalf.
- That the benefits to which you are entitled, including Medicare, private insurance, and other health plans, will payable to the Stillwater Primary Care.
- That the assignment will remain in effect until revoked by you in writing. A photocopy of this assignment will be considered as valid as the original.
- That you are financially responsible for all charges, regardless of whether it is paid by your insurance.

THANK YOU FOR YOUR COOPERATION