NEW PATIENT INFORMATION

* Please provide your insurance card to the receptionist prior to completing this form.

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Last Name	First	M.I.

Appt. Date	M / F	DOB	Age	Social Security

Driver's License	Marital status ❍ Single ❍ Married ❍ Seperated ❍ Divorced ❍ Widowed

Address	City	State	Zip

Email	Home/Cell Phone	Work Phone

Occupation	Employer	Employer Address

Referring Doctor	Referring Doctor's Phone	Primary Doctor

PARENT, SPOUSE, OR REPONSIBLE PARTY (if different from patient):

Last Name	First	M.I.	Relationship to Patient

Address	City	State	Zip

Home/Cell Phone	Work Phone	Email

EMERGENCY CONTACT INFORMATION

Emergency Contact Name

Address	City	State	Zip

Phone	

INSURANCE COVERAGE

Insurance Co Name

Claim Center Address	City	State	Zip

Name of Policy Holder (Insured)	Policy Holder (Insured) DOB

Policy #	Group Name or #	HMO / PPO

If Parent or Guardian, please specify relationship to the patient ☐ Mother ☐ Father ☐ Other (please explain):

FOR OFFICE USE ONLY

Benefit Information:

❍ **HMO** ❍ **EPO**

❍ **POS** ❍ **PPO**

Verified (Name):____________________

	In	Out
Deductible	__________	__________
Coverage	__________ %	__________%
Out of Pocket	__________	__________

Co-pay __________ **Day Max** __________

Pre certification ❍ **Yes** ❍ **No**

Authorization Phone # ____________________

Authorization # ____________________

Authorization Representitive____________________

2403 Castillo Street • Suite 203 • Santa Barbara, California 93105 • P / 805.823.6688 • F / 805.617.1743 • www.snc.md

PROPERTY OF MEDBRIDGE. USED BY PERMISSION ONLY.