New Patient Information Sheet (PLEASE PRINT)

Date:_____

REFERRED BY:	STREET ADDRESS, CITY, STATE AND ZIP CODE	PHONE NO.

CELL PHONE:_____ EMAIL:_____

Patient's Name	Marital Status (S M W D SEP)	Date of Birth	Age	Social Security No.

Street Address Permanent Temporary	City and State	Zip Code	Home Phone No.

Mailing Address, If Different Than Above:	Driver's License No.

Patient's Employer	Occupation (Indicate if a Student)	How Long	Business Phone No.

Employer's Address

☐ Spouse or ☐ Parent's Name	Phone No.	Date of Birth	Social Security No.

Spouse or Parent's Employer	Occupation	Business Phone No.

Nearest Relative Other Than Spouse	Relationship	Phone No.

Family Physician	Emergency Contact	Phone No.

Has any member of you immediate family been treated by our Dr. Ramseur Before?

Primary Insurance
Insurance Company Name & Address

_____
_____
_____

Telephone_____
Insured's Name_____
Group Number_____

Secondary Insurance
Insurance Company Name & Address

_____
_____
_____

Telephone_____
Insured's Name_____
Group Number_____

Insurance Authorization and Assignment (Please Read and Sign)

I hereby Authorize Dr. James E. Ramseur, Jr., M.D. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any and all amounts not covered by insurance.

Date_____ Signature_____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments for major care. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.