

- E. Diane Steeves, A.R.N.P
- Ralph Imlay, M.D.
- Neal Secrist, D.O.

NEW MEDICAL HEALTH CARE
10525 W. 21st St. N., Wichita, KS 67205
316-773-1212

- William Simon, D.O.
- Gregory Lakin, D.O.
- Roger Unruh, D.O.

Date: _____

PATIENT INFORMATION FORM

MINOR

PLEASE PRINT - Our staff will be happy to assist you in completing this form.

NAME: Last		First		MI		Maiden	
HOME ADDRESS:		CITY		STATE		ZIP	
HOME PHONE: () CELL PHONE: ()		BIRTH DATE		AGE		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED				SOCIAL SECURITY NUMBER			
STUDENT STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a student				NAME OF EMPLOYER			
EMPLOYER'S ADDRESS				WORK PHONE # ()			
NAME OF RESPONSIBLE PARTY (if other than self) Relationship to patient				DOB			
HOME PHONE # ()		CELL PHONE # ()		SOCIAL SECURITY #			
HOME ADDRESS		CITY		STATE		ZIP	
EMPLOYER'S NAME				WORK PHONE # ()			
OTHER PARENT'S NAME				DOB			
HOME PHONE # ()		CELL PHONE # ()		SOCIAL SECURITY #			
HOME ADDRESS		CITY		STATE		ZIP	
EMPLOYER'S NAME				WORK PHONE # ()			
NEAREST RELATIVE (Not living with you)							
ADDRESS				HOME PHONE # ()			

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE							
INSURANCE ADDRESS		CITY		STATE		ZIP	
INSURED'S ID #		GROUP NUMBER		INSURED'S SOCIAL SECURITY #		INSURED'S DOB	
SECONDARY INSURANCE							
INSURANCE ADDRESS		CITY		STATE		ZIP	
INSURED'S ID#		GROUP NUMBER		INSURED'S SOCIAL SECURITY #		INSURED'S DOB	

I was referred to this practice by? _____

Names of brothers, sisters, parents who are patients here: _____

PLEASE READ AND SIGN THE FOLLOWING TO HELP US WITH YOUR INSURANCE FILING

I hereby authorize New Medical Health Care to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to same all payments or medical services rendered to me. I understand that my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to New Medical Health Care. I also authorize New Medical Health Care to perform any treatment which is considered necessary by the physician. A photocopy of the authorization and assignment shall be considered as valid as the original.

Patient or Guardian Signature

Date

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION

Name of Beneficiary _____

HIC Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to New Medical Health Care for any services furnished me by New Medical Health Care. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

Date _____