

- 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: ()				BIRTH DATE				AGE				SEX <input type="checkbox"/> Male <input type="checkbox"/> Female							
CELL PHONE: ()																			
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED								SOCIAL SECURITY NUMBER											
STUDENT STATUS								NAME OF EMPLOYER											
<input type="checkbox"/> Full time <input type="checkbox"/> Part-time <input type="checkbox"/> Not a student																			
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 _____