PATIENT INFORMATION

Last Name_____ First Name _____

Address _____ City/State/Zip _____

Primary Phone: _____ ___ Cell ___Home ___ Work

Secondary Phone _____ ___ Cell ___Home ___ Work

Email Address _____ Date of Birth _____

Emergency Contact _____ Relationship _____

Emerg Contact Phone _____ ___ Cell ___Home ___ Work

Insurance Information

Primary Insurance _____ Telephone Number _____

ID # _____ Group # _____

Relationship to Insured

—-- Self (skip to signature) _____ Spouse ____ Dependent Child/Student ____ 0ther

Insured Name _____ Date of Birth _____

Insured Address _____
Street City State Zip

Employer _____ Business Phone _____

I authorize MARIA ARCIA, MD and/or NEWTON SQUARE HEALTH CENTER, PC to release information to process my insurance claims. I also authorize payments of my benefits be made directly to NEWTON SQUARE HEALTH CENTER, PC. I acknowledge responsibility for my deductible, coinsurance and copays designated by my insurer. I also acknowledge that 24 hours is required for cancellation of scheduled appointments to avoid a fee being charged.

Signature _____ Date _____

Pharmacy

Pharmacy Name _____ Telephone _____

Address _____

Allergies

____ No Known Allergies

____ Allergy/Medication Name _____

Onet Date _____

Reaction _____

Severity _____

____ Allergy/Medication Name _____

Onet Date _____

Reaction _____

Severity _____

____ Allergy/Medication Name _____

Onet Date _____

Reaction _____

Severity _____

____ Allergy/Medication Name _____

Onet Date _____

Reaction _____

Severity _____