Date:____________________

New Patient Information
(Please Print Legibly)

Name	Sex	Marital Status	Date of Birth	Social Security Number
Home Address	Cell Phone Number			Home Phone Number
City	State	Zip Code		Drug Allergies
Patient's Employer	Occupation			Business Phone Number
Employer's Address	City, State			Zip Code
Spouse or Parent Name	Spouse /Parent Phone Number		Date of Birth	
Spouse's or Parent's Employer	Address		City, State, and Zip	

Do you have a telephone answering machine at home? Yes ☐ No ☐

If so, may we leave messages from this office on the machine? Yes ☐ No ☐

Who referred you to us? ____________________________________

In case of an emergency, person to notify (Not living at the same address)

Name:__________________________ Relationship: _____________________ Phone: _______________

Person Responsible for Payment	Street Address, City, State, and Zip			Home Phone Number
Social Security Number	Date of Birth	Employer	Employer Address	
Insurance Company	Policy Number		Group Number	Effective Date
Primary Care Physician				

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. 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.

I hereby authorize Alan Nili, D.O. Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature _______________________________________ Date ______________________________