**NEW PATIENT BILLING INFORMATION**

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| **Patient Name** | **Guarantor’s (Policy Holder’s) Date of Birth** | |
| **Date of Birth (Patient)** | Address | |
| Home Phone | Work Phone | |
| Mobile/Cell Phone | Email Address | |
| Patient Employer (or School Name if minor) | Occupation (if applicable) | |
| Is this an Auto Insurance case?  Is this a Worker’s Comp case?  **PRIMARY**  Insurance co. name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claims Address/Phone  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Effective Date of policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Injury (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referral necessary to see a specialist? | If Yes, is Auto Primary or Secondary  Is an attorney involved?  **SECONDARY** or **AUTO**  Insurance co. name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claims Address/Phone  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective date of policy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Injury (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If this is an Auto case you must include the adjuster’s contact information, claim number and date of accident.  If Auto case please indicate where and when you had prior treatment.  If this is a Worker’s Comp case you must include the claim # and address with date of injury.  If there is Attorney on case we must have name and contact info for release of records | | |
| Primary Care/Referring PHYSICIAN NAME, ADDRESS, PHONE, FAX- Please provide | | |