# NEW PATIENT INFORMATION

**Patient Last Name________________________ First___________________________ Middle_________**

**Home Address_____________________________________ City_________________ Zip____________**

**Home Phone#_________________Cell Phone#_________________Work Phone #__________________**

**Sex: M / F DOB:______/______/______ S.S.#______/_____/______ Email _______________________**

**Employer__________________ Occupation_______________ Address__________________________**

**Marital Status: Single Married Divorced Widow Reffered by _____________________________**

**Emergency Contact ___________________Phone # ____________________ Relation_______________**

**Family Doctor ________________________Phone #____________________Pharm#________________**

***************Please provide your insurance card & drivers license so a copy can be made**************

## INSURANCE DETAILS

**Primary Ins __________________ Insured's Name______________________ DOB:_____/______/_____**

**Relationship to Patient_________________ID #_______________________ Group#________________**

**Insured's Employer_______________Work #_____/_____/______ Insured's S.S.#______/_____/_______**

**Secondary Ins__________________ Insured's Name_____________________ DOB:_____/_____/______**

**Relationship to Patient_________________ID # _______________________ Group#________________**

**Insured's Employer_______________Work #_____/______/_____ Insured's S.S.#______/_____/_______**

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### METHOD OF PAYMENT

**Party Responsible for payment_________________________ Relationship______________________**

**To our patients who present insurance information: please be advised that your insurance coverage is subject to all terms and provisions of your plan applicable at the time services are rendered. We will make an attempt to verify your coverage on current information available. Patients must meet eligibility requirements of the plan to have benefits available for service. I understand that I am fully responsible for all amounts not paid by insurance.**

**I hereby authorize Dr. Maria C. Yango-Eugenio for treatment of condition. I authorize Dr. Yango to release information to insurance companies regarding care rendered. I further authorize direct payment to say doctor for benefits due to me for services rendered and authorize my insurance company to make such payment.**

**In the event that I have a high deductible or co-insurance, I authorize the billing department to withdraw monthly payments starting at $_____ (dependent of balance) from a credit card provided below.**

**Credit Card Type____ #_______________________ Exp date___________Name_____________________**

**Signature of Patient/Responsible Party_________________________ Date ______/________/________**