OppenheimerEndocrinology
DIABETES & THYROID CARE

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# NEW PATIENT INFORMATION

Patients Name _____ Social Security No _____
(First) (Middle Initial) (Last)

Address _____
(Street or Route) (City) (State) (Zip)

Home Phone _____ Date of Birth _____ Age _____ Sex _____Marital Status _____

Occupation _____ Cell Phone _____ Yes ❑ No ❑ Leave Medical Message on answering machine.

Employer _____ Business Phone _____

Employer's Address _____
(Street or Route) (City) (State) (Zip)

Referring Doctor _____ Primary Doctor _____

Address _____ Address _____

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Responsible Party (if other then patient) _____

Address _____
(Street or Route) (City) (State) (Zip)

Who to contact in case of emergency: _____

Phone _____ Address _____

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Is this Work Related ❑ Yes ❑ No Is this Auto Related ❑ Yes ❑ No Date of Injury _____

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How did you hear about us? Physician___ TV___ Radio___ Newspaper___ Friend____ other:_____

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## Insurance Information

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

City & State _____ City & State _____

Name of Policy Holder _____ Name of Policy Holder _____

Policy Holders Date of Birth _____ Policy Holders Date of Birth _____

Policy ID Number _____ Policy ID Number _____

Group Number _____ Group Number _____

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Does your insurance Company require prior authorization for hospitalization? ❑ Yes ❑ No

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**AUTHORIZATION FOR TREATMENT:** Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic and medical treatment by my physician, his assistants, or his designees including consulting physicians, employees, and students in educational programs affiliated with Oppenheimer Endocrinology, as is necessary in the judgment of my physician. I consent to testing for HIV (AIDS) and or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

**RELEASE OF INFORMATION:** I hereby authorize Oppenheimer Endocrinology to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to the third party payers and/or their reviewing contractors to comply with preadmissions review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

**ASSIGNMENT OF BENEFITS:** Authorization is hereby granted for the direct payment to Oppenheimer Endocrinology for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

_____ _____
Patient Signature Patient Representative

_____ _____
Date Relationship to Patient