

# Welcome To Our Practice

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ SS# \_\_\_\_\_  
Male Female Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell# \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Circle Appropriate: Minor Single Married Separated Divorced Widowed  
Patient's or Parents Employer \_\_\_\_\_ Work # \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or parent' name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
IF Patient is a student, name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver license# \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work phone \_\_\_\_\_

## Primary Insurance Information

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Do you have any additional insurance Yes No If yes, complete the following:

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

## Authorization & Release

I certify that I, and or my dependent(s) have insurance coverage with \_\_\_\_\_ *Name of Insurance Company (ies)* and authorize payments directly Dr. Jennifer Gordon- Maloney of all insurance benefits, if any, otherwise payable to me for the service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. We allow 45 days for insurance payment, after which the balance will then be billed to you, to be paid with in 15 days .The above-name physician may use my health care information and may disclose such information to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for the service and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient ( or parent if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of authorized representative of  
Stonecrest OMS, Inc.

\_\_\_\_\_  
Date