

New Patient Information

Date: ___ / ___ / _____

Name	First	MI	Last
Address	Apt #		
City	State	Zip	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	___ / ___ / _____ SSN - -
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Same-Sex Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Emergency Contact	Name	Relationship	Phone () -
Primary Care MD	Name	Phone () -	
Medications			

Contact Information: Please provide your contact information. In the box to the right of "Pref," please mark "1" for your first choice of how to be contacted, "2" for your second choice, etc. If I should **not** contact you by this method, please mark "NO."

Home Phone	Pref	() -	Work Phone	Pref	() -
Cell Phone	Pref	() -	E-mail	Pref	

Employment/School Information

Employment	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled				
Employer or School	Name				
	Address				
City	State	Zip			

Insurance Information: Primary Insurance (if being used)

Insurance Name	Name	Address			
City	State	Zip	Phone	() -	
Subscriber ID	Group #	Policy #			
Subscriber Name	"Same" if same as patient				
Subscriber Address	City, State, Zip; "Same" if same as patient				
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	___ / ___ / _____	Relation to Pt	Co-Pay

Patient's Name	Please print
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Financially Responsible Party (Who should be billed for balances? Write "same" if same as patient.)

Name	First	MI	Last
Address			
City	State	Zip	Apt #

Insurance Information: Secondary Insurance (if any)

Insurance Name	Name	Address		
City	State	Zip	Phone () -	
Subscriber ID	Group #	Policy #		
Subscriber Name	"Same" if same as patient			
Subscriber Address	City, State, Zip; "Same" if same as patient			
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	___ / ___ / _____	
	Relation to Pt		Co-Pay	

Patient (or Guardian): Read, sign, and date **all** sections

Release of Information	I authorize Nathaniel S. Kuhn, MD to release any medical or other information necessary to process insurance claims to his billing service and to the insurance companies and/or case management organizations that are providing my mental health insurance. I also request payment of government benefits either to myself or to the party who accepts assignment below.
	Signed: _____ Date: _____
Assignment of Benefits	I authorize payment of all medical benefits directly to Nathaniel S. Kuhn, MD.
	Signed: _____ Date: _____
Patient's Responsibility for Payment	I understand that I am responsible for payment for services that are not covered by my insurance plan for whatever reason, including denial of medical necessity, late cancellations, missed appointments, same day/same charge duplication by different providers, etc. I also understand that if my balance is not paid in a timely fashion, I may liable for additional charges, such as interest, collection fees, etc.
	Signed: _____ Date: _____