

**New Patient Information Sheet**

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**Patient Information**

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Name:(First) \_\_\_\_\_(MI)\_\_\_\_(Last)\_\_\_\_\_

Date of Birth\_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital Status: S M W D

Address: Street \_\_\_\_\_

City\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ SS#: \_\_\_\_\_ DL# \_\_\_\_\_

Work #: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

If Student, School Name: \_\_\_\_\_

**Responsible Party or Spouse Information**

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Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Work # \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Friend or Relative Not Living With You: \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby assign, transfer, and set over to Synergy Studio all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Insurance Information

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Insurance Co: \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Group # \_\_\_\_\_ Certificate/ID # \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: Self Spouse Dependent

Insured's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Insured's SS # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claims more quickly. Thank you.

## Insurance Information

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Insurance Co: \_\_\_\_\_ Phone# \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Group # \_\_\_\_\_ Certificat/ID # \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: Self Spouse Dependent

Insured's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F