IDL MEDICAL PA

☐ New Patient Information

☐ Change of Patient Information

Patient Information: (PLEASE PRINT CLEARLY)

Mr.
Ms.
Mrs.
Dr. _____

First Name | Middle Name | Last Name

_____ ___/___/_____ ☐Female or ☐Male

Social Security Number | Date of Birth

_____

Address | City, State | Zip Code

_____ _____ _____

Home Phone Number | Work Phone Number | Cellular Phone Number

☐N/A ☐Part Time ☐Full Time _____

Student Status | School Presently Attending

Patient Demographics: (optional)

_____

Ethnic Origin | Marital Status | Blood Type

_____

Emergency Contact | **Relationship** | **Phone Number**

Guarantor Information: (who will be financially responsible for patient) **Check here if self:** ☐

Mr.
Ms.
Mrs.
Dr. _____

First Name | Middle Name | Last Name

_____ ___/___/_____ ☐Female or ☐Male

Social Security Number | Date of Birth

_____

Address | City, State | Zip Code

_____ _____ _____

Relationship to Patient | Home Phone Number | Cellular Phone Number

_____

Employer | Occupation | Work Phone Number

_____ _____

Driver's License or ID Number | State

PLEASE COMPLETE REVERSE SIDE

Insurance Coverage Information:

_____ _____
Insurance Company Name Policy Number

_____ _____
Group Number Effective Date

_____ _____
Primary Insurance Holder (if other than guarantor) **Relationship to Member**

Type of Policy: ☐HMO ☐POS or PPC ☐PPO ☐Medicare ☐Medicaid
☐Medicare HMO

_____ _____
Secondary Insurance Company Name Policy Number Group Number

I understand that payment for services rendered is ultimately my responsibility.

_____ _____
Signature **Date**