



### **New Patient Questionnaire**

Please answer all the questions completely.

Name: \_\_\_\_\_ Second Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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

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

Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employment Status: (please circle) Full Time Part Time Unemployed Student

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Patient's Relation to Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Patient's Relation to Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Emergency Contact: (Name, relation & phone number) \_\_\_\_\_

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I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring physicians and to my insurance company. I allow fax transmittal of my medical records. I acknowledge full responsibility for services rendered by Dolphin Medical Group. I understand payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Kathryn Price, MD, Lura Springfels, ARNP/Dolphin Medical Group should they elect to receive such payment. I have fully read and understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_