NEW PATIENT INTAKE

PLEASE PRINT

Patient Name: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Trans

Address: _____ Phone: Home _____
City/State/Zip: _____ Mobile _____
Work _____
Email: _____ Marital status: S M W D Sep

Occupation: _____
Employer: _____

Spouse/Parent/Emergency Contact:
Name: _____
Relationship: _____
Phone: Home _____
Mobile _____
Work _____
Address:_____

Subscriber/Insurance policy holder:
Same as Patient: ☐ Same as Contact: ☐
Name: _____
Date of Birth: _____
Relationship: ☐Spouse ☐Parent ☐Other
Employer: _____

SIGNATURE ON FILE

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my Insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Signature: _____
Name (printed): _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Dr. Lucy Hornstein's Notice of Privacy Policies.

Signature: (optional) _____
Name (printed): _____ Date: _____

[Administrative use only]
Acknowledgement of Receipt of Notice of Privacy Practices not obtained because:
☐ Individual declined to sign ☐Communication barriers ☐Emergency situation ☐Other_____