NEW PATIENT QUESTIONNAIRE

Today's Date: ____ / ____ / _____ ☐ **Dr. Wallace** ☐ **Dr. Beaman**

Your Name: _____ **[ ] Male [ ] Female**

Date of Birth: ____ / ____ / _____ **Age:** _____**Social Security Number:** _____ - _____ - _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____) _____ **Email:** _____

Mobile Phone: (____) _____ **Mobile Carrier:** _____

Emergency Contact: _____**Relationship to Patient:** _____

Home Phone: (____) _____ **Mobile Phone**: (____) _____

Employer: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

How did you find our phone number? :_____

BILLING AUTHORIZATION

A. I hereby authorize the release of any health care information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any health care benefit from the third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products/services rendered.
C. I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care/treatment, any fees for products or professional services rendered will be immediately due and payable.

Cancellation Policy: If you cannot make your appointment, your consideration to call and reschedule would be appreciated. The sooner the appointment is rescheduled or cancelled, the greater the possibility for that appointment time to be filled by another patient.
Anyone who fails to show up for an appointment and or does not provide 24 hour notice prior to the scheduled appointment may be subjected to a fee of $25. These charges will not and **cannot** be billed to your insurance provider.
.

Patient Name (Print): _____ **Date**: _____

Patient/Guardian Signature: _____ **Date**: _____