NEWCare
New England Wound & Ostomy Care

PATIENT INFORMATION FORM

Patient Name: _____ **DOB:** _____

Social Security #: _____

Address: _____

Mailing/P.O. Box: _____

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

Telephone: _____ **Cell:** _____ **Work:** _____

Email: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ **Location:** _____

Emergency Contact Name: _____

Phone: (home) _____ **(cell)** _____ **(work)** _____

Relationship: _____

Insurance Information:

Primary: _____ **Please present insurance card** *(at the time of your first visit)*

Subscriber ID#: _____

Secondary: _____ **Please present insurance card** *(at the time of your first visit)*

Subscriber ID#: _____

Name of Subscriber: _____ **Date of Birth:** _____

Relationship to the patient: ☐ Mother ☐ Father ☐ Spouse ☐ Partner ☐ Other

Guarantor (person responsible for paying bill): _____

I hereby authorize the release of any medical or other information necessary to process insurance claims. Please also be advised it is up to you to know your deductibles, co-insurance, and co-pays. If a service that is provided by us is not covered by your insurance, you will be responsible for the billed amount. Arrangements can be made for payment plans. Any questions as to your coverage should be directed by you to your insurance company to verify your coverage.

Signature: _____ **Date:** _____

Please note that the required copay will be collected at the time of your visit.