The Kennedy Clinic PLLC

New Patient Information

Patient Name _____
Last First Middle Initial

Address: _____

Phone (home): _____ (cell): _____ Email: _____

Date of Birth: ____/____/_____* Gender: M F Marital Status: S M D W SS#: _____

Race: _____ (may decline) Ethnicity: _____ (may decline) Language: _____

Emergency Contact: _____ Relationship: _____

Phone 1: (_____)_____ Phone 2: (_____)_____

Occupation: _____ Employer: _____

Employer's Address: _____
Street City State Zip

Work Phone (_____)_____ Employed: ___ Full Time ___ Part Time

Are you a student? __ YES __ NO If Yes: __ Full Time __ Part Time

Primary Insurance: _____

Primary Insured's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Relationship to Patient: _____

Secondary Insurance: _____

Secondary Insured's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Relationship to Patient: _____

Whom may we thank for referring you to us? _____

Preferred Pharmacy: _____
Name Location Phone

NOTE: YOU MUST ALLOW NO LESS THAN 24-48 HOURS FOR MEDICATION REFILLS. PATIENTS ARE ASSESSED $25 FOR AN APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE.

I hereby assign all medical benefits, including major medical to which I am entitled, Medicare, and other government-sponsored programs, private insurance, and any other health plan to The Kennedy Clinic PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any and all charges, whether or not paid by said insurance. I hereby authorize assignee to release all information to secure the payment.

_____ _____
Patient, Parent, or Guarantor Signature Date

*Patients under the age of 18 must be accompanied by parent or guardian on the first visit.