Idaho Diabetes & Endocrine Associates, P.A.

PATIENT INFORMATION

Please Print out, Fill in & Bring to Your First Appointment

Today's Date	Doctor		New Patient to Clinic
Last Name:	First:	Middle:	Marital Status: Single Separated Married Widowed Divorced
Maiden Name:	Email Address:	Birth Date:	Age: / Sex: M F
Street Address:		SS#	Home Phone: ( )
P.O. Box	City:	State:	Zip Code:
Occupation:	Employer:	Length of Employment	Employer Phone #
Husband/s or Parents Name:		SS#	
Husband/s or Parents Employer:		Phone# ( )	

Patient's Parents or Nearest Relative:

Name:	Relationship:	Phone# ( )	
Street Address:	City:	State:	Zip Code:
Referred By:		Family Doctor:	

Information may be released to: Spouse Parent Other No One

(Please give your insurance card to the receptionist)

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Co. Name:	Insurance Co. Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone #:	Phone #
Pre-Cert Phone #:	Pre-Cert Phone #:
Insured Person:	Insured Person:
Date of Birth:	Date of Birth:
Policy #:	Policy #:
Group # or Name:	Group # or Name:
Effective Date:	Effective Date:
Relationship to Subscriber:	Relationship to Subscriber:

I Authorize the Release of any Medical Information Necessary, and Authorize Payment of Medical Benefits to the physician from my insurance carrier; I also authorize the release of any medical information necessary to any doctors that I may be referred to by the clinic. I understand any charges incurred are my responsibility regardless of insurance status.

Patient / Guardian Signature **Date**