MONICA OGANES & ASSOCIATES

New Patient Information

PATIENT Name (Last) _____(First)_____(MI)_____

Address _____City_____ State _____ Zip _____

Sex: M F School _____ Grade_____

Birth Date _____ Age _____ Social Security# _____

Home Phone ( ) _____ Cell Phone ( ) _____

Emergency Contact_____ Home/Cell Phone ( ) _____

Address_____City_____ State_____Zip _____

Person Responsible for Payment? (only if different from above)

Name _____ Relationship _____ DOB _____
Employer _____

Home Phone ( ) _____ Work Phone ( ) _____

Referral Source

Name (Last) _____(First)_____(MI)_____

Address _____City_____ State _____ Zip _____

Work Phone ( ) _____Email_____

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

_____

(Alternate Address) (City) (State) (Zip)

B. Is it okay to leave messages at the contact number(s) provided above? Yes No

C. It is **YOUR** responsibility to bill your Insurance Company and **YOU** will be personally responsible for the bill at our office.

I, the undersigned (patient or legal guardian), authorize medical/mental health/educational treatment to be rendered by Monica Oganes & Associates and assume financial responsibility. In the event the account is **not paid in full within 30 days of the due date,** the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the state. I also authorize the release of my medical records to my physicians and insurance carriers as needed.

Patient (Parent/Legal Guardian) Name_____

Signature _____ Date_____ Revised 3/19/13