Advanced Therapy Solutions

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

Patient Information

Account #	Social Security #	Title	Last Name	First Name	MI

Street Address (Road or Street)	(Apartment Number or Second Address Line)

Zip Code	City	State

Home Phone	Cell Phone	Nickname

Birthday	Sex (M, F)	Referring Doctor	Referring Doctor UPIN #

Marital	Employment	Student	Relationship to Insured
☐M-Married ☐ W-Widowed ☐S-Single ☐D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	☐SE-Self ☐SP-Spouse ☐OT-Other ☐CH-Child

Employer Code (Office Use Only)	Employer Name

Employer Street Address (Road or Street)

Zip Code	City	State	Business Phone	Ext

INSURANCE INFORMATION

Primary Insurance Company Name

Mailing Address

Insurance Telephone #

Policy #

Group #

Secondary Insurance Company Name

Mailing Address

Secondary Telephone #

Policy #

Group #

Guarantor Information

Social Security #	Title	Last Name	First Name	MI

Birthday (REQUIRED)	Sex (M, F)	Relationship to Insured

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related:	Accident related:	Date of first symptom or accident:
☐ Yes ☐ No	☐ Auto ☐ Other ☐ No	

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.	I authorize payment of medical benefits directly to this practice for the services rendered.
Signed Date	Signed Date