The Bauman Clinic
a medical corporation

# New Patient Registration

Welcome to The Bauman Clinic, AMC. Please fill out the information on this form as accurately as possible so that we may better serve you. Note that this form will become part of your medical record.

Today's date _____

Patient Name _____

Mailing Address _____City_____Zip_____

Home phone _____ Mobile phone _____ Work phone _____

Patient SS number (MANDATORY) _____ Email address _____

Date of birth _____ Occupation _____ Employer _____

Primary care doctor _____ Doctor's phone number _____

Emergency contact: _____
Name Relationship Phone Number

Who else is living in your home? _____

_____

_____

How did you find out about The Bauman Clinic? ☐ I am a transferring or former patient.

☐ another doctor therapist ☐ family member ☐ friend

☐ newspaper advertising ☐ website ☐ other _____

# Insurance & Billing Information

Payment in full is required at the time of service, unless other payment arrangements have been made.

At present, The Bauman Clinic is contracted with a very limited number of insurance companies. For most of you, our clinic is considered an "out of network" provider. Please be aware that you may be entitled to reimbursement from your insurance company even if our clinic is "out of network". You ~~will~~ MAY be given an invoice at the time of service and you may mail this in immediately to your insurer. You will then be reimbursed by the insurer according to your policy. The amount reimbursed varies, depending on your deductible, type of policy, etc.

Please talk with us about reduced fees, insurance courtesy billing, and payment options. Proper care of your health can be expensive and we want to help you provide for this as best we can. We are happy to help.

If we will be billing your insurance, please provide the following information.

Primary insurance company: _____

Name of insured: _____

Insured SSN: _____

Insured Date of Birth: _____

Employer: _____

Member Number: _____

Group or Policy Number: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Is there a secondary insurance? ☐ Yes ☐ No

Permission is given to provide/exchange information with my insurance company.
I have read the above and agree.

_____
Signature Date

# Patient Medical History

Date of most recent physical exam:_____ Doctor: _____
Significant findings at this exam?_____

List any medication you are on at this time, including name, dosage and frequency. Please include over-the-counter drugs that you take on a regular basis._____

_____

_____

Do you have any allergies to medicine or food? If so, list._____
_____

Do you have any current medical problems, illnesses, or concerns? (High blood pressure, asthma, diabetes, problems with dizziness, headaches, back pain, stomach upset, muscle pain or weakness, etc.) Please list._____
_____
_____
_____
_____

Have you had any medical hospitalizations or surgery? If so, list._____
_____

Describe level of use of the following:

Caffeine_____
Tobacco_____
Alcohol_____
Other drugs_____

Do you have any relatives with mental health issues? If so, please list relationship and issue (if known)._____
_____
_____
_____ ____
_____