



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.

Foday's date			
Patient Name			
Mailing Address		City	Zip
Home phone	Mobile phone	Work ¡	phone
atient SS number (MAN	DATORY)	Email ac	ldress
Date of birth	Occupation	Employ	er
rimary care doctor		Doctor's phone number	r
imergency contact:	Name	Relationship	Phone Number
Who else is living in your	home?		
low did you find out al	oout The Bauman Clinic	? 🔲 I am a tran	sferring or former patient.
another doctor	therapist	☐ family member	☐ friend
newspaper a	dvertising	website \Box	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 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.

Drimany incurance company

- Timary insurance company:			
Name of insured:			
Insured SSN:			
Insured Date of Birth:			
Employer:			
Member Number:			
Group or Policy Number:			
Patient's Relationship to Insured:	Self Dependen	-1	
ls there a secondary insurance?	☐ Yes	□ No	
Permission is given to provide/ex have read the above and agree.	xchange informatior	with my insura	ance company.
	Signature		Date

Ĺ	Patient Medical History
Da Si	tte of most recent physical exam: Doctor: gnificant findings at this exam?
Li in	st any medication you are on at this time, including name, dosage and frequency. Please clude over-the-counter drugs that you take on a regular basis.
•	
Do	you have any allergies to medicine or food? If so, list
ast	you have any current medical problems, illnesses, or concerns? (High blood pressure, thma, diabetes, problems with dizziness, headaches, back pain, stomach upset, muscle pain or eakness, etc.) Please list
 Ha	eve you had any medical hospitalizations or surgery? If so, list
De	cscribe level of use of the following: Caffeine Tobacco Alcohol Other drugs
Do kn	you have any relatives with mental health issues? If so, please list relationship and issue (if own)

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