

# New Patient Form



## Physicians Health and Injury Center

4 Christopher Columbus Avenue  
Danbury, Connecticut 06810

(203) 798-WELL (9355)

Fax: (203) 778-6612

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

Single  Married  Divorced  Widowed

Social Security #: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Who referred you to our office: \_\_\_\_\_

### I wish to be contacted in the following manner (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax |
| <input type="checkbox"/> Work Telephone<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other<br>_____<br>_____  |

### Financial Responsibility – Assignment Benefits

I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits directly to Physicians Health and Injury Center for services furnished to me. I authorize release of information to process claims for services furnished to me by Physicians Health and Injury Center. I permit a copy of this authorization to be used in place of the original.

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_