Advanced Therapy Solutions, Inc

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:	Email Address

Birthday	Sex (M, F)	Referring Doctor	EMAIL Address

Marital	Employment	Student	Returning Doctor's Appointment
☐M-Married ☐ W-Widowed ☐S-Single ☐D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐P-Part ☐ N-None	☐ P-Part ☐ F-Full ☐ N-None	

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 #

COMPLETE IF COVERAGE IS IN SPOUSE/PARENT'S NAME

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.

_____

Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

_____

Signed Date