

**NEW PATIENT INFORMATION
STEPHEN GIST, M.D.**

Today's Date:			
Patient's Name (Last, First, M.I.)		Home phone (area code) ()	
		Home fax (area code) ()	
Street Address		City, State, Zip Code	
Social Security Number / /	Date of birth / /	Sex M F	Marital status M S D W
Current employer	Address	Work phone (area code) ()	
Name of spouse	Spouse's employer	Spouse's work phone (area code) ()	
Local contact (<u>not</u> living with you)	Street address	City, State, Zip Code	
Relationship to you	Work # ()	Home# ()	
Referred by:			

RESPONSIBLE PARTY FOR PAYMENT IF OTHER THAN PATIENT

Name (Last, First, M.I.)		Home phone (area code) ()	
Street address		Social security number / /	
City, State, Zip Code	Date of birth / /	Sex M F	
Current employer	Address	Work phone (area code) () ext.	

Please list current and former doctors:			
Doctor	Specialty	Doctor	Specialty

I hereby assign to Medical Specialists Associated any money payable to me under hospitalization or other insurance coverage, and/or other arrangements with third parties, for payment of such services. I also authorize Medical Specialists to furnish my insurance company the medical information requested. I also agree to be responsible for any testing or treatment that may or may not be considered by my insurance company, to be medically necessary. I also agree to pay Medical Specialists Associated \$60.00 for no show appointments if not properly canceled within 24 hours prior to the scheduled appointment.

Signature: _____ Date: _____