SHADID
MEDICAL GROUP

Phone (405) 252-8761 • Fax (405) 252-8762

New Patient Information

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE

SOCIAL SECURITY NO.:	MARITAL STATUS: ▪ Single ▪ Married ❑ Widowed ▪ Divorced ▪ Separated	SPOUSES NAME:	EMAIL:

PATIENT'S ADDRESS:			REFERRING PHYSICIAN:
CITY:	STATE:	ZIP CODE:	ARE YOU: ▪ Employed ▪ Full-Time Student ▪ Part-Time Student ❑ Retired
HOME PHONE: ( )	WORK PHONE: ( )		CELL PHONE: ( )

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ▪

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

EMPLOYMENT INFORMATION

Patient's Employer _____ Ph# _____

Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

Father _____ Employer _____ Ph# _____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:	
HOME PHONE: ( )	RELATIONSHIP TO THE PATIENT:

THIRD PARTY BILLING

Is Your Injury Work Related?	▪ Yes	▪ No
Is This Injury Due To An Accident?	▪ Yes	▪ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	▪ Yes	▪ No

I Authorize the RELEASE of any MEDICAL INFORMATION if necessary, to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature _____ Date _____