DR. CARL J. MATTIA

638 Newtown Yardley Road, Suite 1-H • Newtown, PA 18940
Phone: 215-321-1200 Fax: 215-321-6100

NEW PATIENT INFORMATION

Welcome! Please fill out this form as completely as you can. If a question does not apply to you, write "N/A." Please ask our staff if you need help.

1. ABOUT YOU

First name:	Last name:
Middle initial:	Date of birth (MM/DD/YYYY):
☐ Male ☐ Female	Employer (optional):
Street address:	City:
State:	ZIP code:
Home phone:	Cell phone:
Emergency contact name:	Emergency contact phone:
Primary care doctor:	Who referred you to our office?
What is the reason for your visit?	

2. YOUR INSURANCE

Please bring your insurance card(s) and photo I.D. to your appointment. Complete the information below for each plan you have.

PRIMARY INSURANCE	
Insurance company:	Name of person insured:
Insured person's date of birth:	Relationship to patient:
Policyholder's name and date of birth:	Policy or member ID number:
Group number:	Effective date:
Insurance address:	City, state, ZIP:
Specialist Copay:	Is a referral required? ☐ Yes ☐ No

SECONDARY INSURANCE (if you have one)	
Insurance company:	Name of person insured:
Insured person's date of birth:	Relationship to patient:
Policyholder's name and date of birth:	Policy or member ID number:
Group number:	Effective date:
Insurance address:	City, state, ZIP:
Copay:	Is a referral required? ☐ Yes ☐ No

3. PLEASE READ AND SIGN

Permission to bill insurance and share medical information

I give Dr. Carl J. Mattia's office permission to share the medical and billing information needed to process my insurance claim. I assign insurance payments for services to Dr. Carl J. Mattia. I understand that I am responsible for charges not paid by my insurance, including any amounts I owe under my plan.

Please check each box to show that you understand:

☐ I understand that my copay is due at the time of my visit.

☐ I understand that I may be charged a $25 fee if I miss an appointment without notifying the office 24 hours in advance.

☐ I have received and read the office's HIPAA Notice of Privacy Practices and agree to follow the office's policies. (Available for review at the office)

Patient or legal representative signature:	Date:

Please ask our staff if you have questions about any part of this form.