

**NEW PATIENT INFORMATION**  
**JEFF B. GOUDREAU, M.D., F.A.C.P.**

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: \_\_\_\_\_