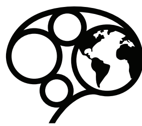


NEW PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME:

Last:_______________ First:_______________ Middle:_______________

Mailing Address:_______________ Email:_______________

Preferred Contact # ☐ Home Phone #:_______________ ☐ Cell Phone #:_______________

Birth Date: / / Age:_______________ Gender:_______________

Social Security #:_______________

Patient's Employer:_______________ Employer Phone #:_______________

We are now required to collect Race, Ethnicity and preferred language. You may choose "Prefer not to answer".

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefer not to answer
- ☐ Other
- ☐ White

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Prefer not to answer

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Prefer not to answer
- ☐ Other _______________

INSURED'S EMPLOYER:

Company Name: _______________ Occupation: _______________

Company Address:_______________

Years Employed:_______________ Employer Phone #:_______________

Spouse/Parent ***(person to be billed if patient is under age 18)***

Name:_______________ Birth Date: / / SSN:_______________

Employer Name:_______________ Address:_______________

Phone:_______________ Occupation:_______________

PRIMARY INSURANCE Name: _______________ Phone #:_______________

Subscriber Name: _______________ Member ID#:_______________Group #:_______________

Effective Date: / / Relationship to Insured:_______________ Subscriber DOB: / /

Is this health insurance a benefit of employment? Y / N

SECONDARY INSURANCE Name: _______________ Phone #:_______________

Subscriber Name: _______________ Member ID#:_______________Group #:_______________

Relationship to Insured:_______________ Subscriber DOB: / /

REFERRING PHYSICIAN:

Physician Name: ____ Phone #:____

PRIMARY PHYSICIAN:

Physician Name: ____ Phone #:____

PHARMACY:

Pharmacy Name: _______________________________________ Phone #:____

Address: ____

EMERGENCY & RECORDS CONTACT:

Emergency Contact: _______________________________________ Phone #: ______________________________________

Relationship:____________________________________

Authorized Contacts for Release of Information

Authorized Contact 1: ____________________________________ Relationship: ____________________________________

Authorized Contact 2: ____________________________________ Relationship: ____________________________________

Information Only to be released to "Authorized Contact" listed above.

__________ Medical Information (Health diagnosis, treatment, etc.)

__________ Financial Information (Balance, payment, insurance)

__________ Prescription Pick up

__________ Documentation Pick up

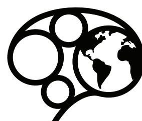
May we leave a voicemail containing medical/personal information?

Yes **No**

PATIENT SIGNATURE:

Print Name: ____

Sign: ____ Date: ____



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