NEW PATIENT REGISTRATION

Date: _____ / _____ / _____

Reason for Visit: _____

How did you hear about us? _____

PATIENT INFORMATION

Legal Name: _____

First Middle Last

Date of Birth: _____ / _____ / _____ Sex at birth: M / F

Preferred First Name: _____ Gender: M / F / Non-binary

Street Address: _____

City: _____ St: _____ Zip: _____

Cellphone: _____

PARENT/LEGAL GUARDIAN INFORMATION

Legal Name: _____

First Last

Relationship to Patient: _____

Street Address: (if different from patient) _____

City: _____ St: _____ Zip: _____

Phone: _____ Alternate Phone: _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Additional adults authorized to receive health information pertaining to patient:

Legal Name: _____

First Last

Relationship to Patient: _____ Phone: _____

IN THE CASE OF A MINOR PATIENT

Patient resides with: _____Relationship to Patient: _____

** If there are documents to prove medical decision-making authority or legal custody, please bring copies to your appointment to scan into the electronic medical record. **

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ **Group Number:** _____

Policy Holder Name: _____ **Date of Birth:** ____/____/____

First Last

Policy Holder's Address: (if different from patient) _____

City: _____ **St:** _____ **Zip:** _____

Secondary Insurance: _____

Policy Number: _____ **Group Number:** _____

Policy Holder Name: _____ **Date of Birth:** ____/____/_____

First Last

Policy Holder's Address: (if different from above) _____

City: _____ **St:** _____ **Zip:** _____

PREFERRED PHARMACY

Name: _____ **Phone:** _____

City: _____ **St:** _____ **Zip:** _____

CERTIFICATION OF INFORMATION

I hereby certify that the above information is true, correct, and complete in all respects.

_____ **Date:** _____ / _____ / _____

Signature of Person Completing this Form

_____

Printed Name

_____

Relationship to Patient