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