NEW PATIENT REGISTRATION (PLEASE PRINT) DATE:

PATIENT INFORMATION

PATIENT NAME: FIRST | MIDDLE | LAST | RESPONSIBLE FOR PAYMENT? Y ☐ N ☐

PATIENT ADDRESS: NUMBER & STREET | APT# | CITY | ST | ZIP | COUNTRY

HOME PHONE NO ( ) | MOBILE PHONE NO ( ) | EMERGENCY PHONE NO ( ) | OTHER PHYSICIAN

DATE OF BIRTH ______________________ | SEX: Male ☐ Female ☐ | MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER ____________________

RACE: ☐ AMERICAN INDIAN or ALASKA NATIVE ☐ ASIAN ☐ BLACK, AFRICAN-AMERICAN ☐ HAWAIIAN or OTHER PAC. ISLAND. ☐ WHITE ☐ DECLINED

ETHNICITY: ☐ HISPANIC or LATINO ☐ NOT HISPANIC or LATINO ☐ DECLINED

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ DECLINED OTHER ____________________________

PHARMACY USED (NAME, ADDRESS, PHONE#):

MAY WE LEAVE CONFIDENTIAL MESSAGES ON:
.EMAIL: Y ☐ N ☐ ANSWERING MACHINE / VOICEMAIL: Y ☐ N ☐ | EMAIL ADDRESS

IF YOU ARE A NEW PATIENT, HOW DID YOU FIRST HEAR ABOUT US (CHOOSE ONLY ONE):
☐ FAMILY/FRIEND/PATIENT (FP) ☐SAW OFFICE SIGN/WALK-IN (SI) ☐ MAILING (MA) ☐ COMMUNITY EVENT (EV) ☐ INTERNET (WE) ☐ ADVERTISEMENT (AD) ☐ INSURANCE PLAN LIST (IN) ☐ EMERGENCY ROOM OR HOSPITAL (EH) ☐ PHYSICIAN REFERRAL (PH) ☐ OTHER (OT) ___________

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE: ( )

IF PATIENT IS A DEPENDENT, GIVE GUARDIAN/PARENT INFORMATION

MOTHER'S NAME: FIRST | MIDDLE | LAST | RESPONSIBLE FOR PAYMENT? Y ☐ N ☐

ADDRESS: NUMBER & STREET | APT# | CITY | ST | ZIP | COUNTRY

HOME PHONE NO ( ) | MOBILE PHONE NO ( ) | EMAIL ADDRESS | EMPLOYER | WORK PHONE NO ( )

FATHER'S NAME: FIRST | MIDDLE | LAST | RESPONSIBLE FOR PAYMENT? Y ☐ N ☐

ADDRESS: NUMBER & STREET APT# | CITY | ST | ZIP | COUNTRY

HOME PHONE NO ( ) | MOBILE PHONE NO ( ) | EMAIL ADDRESS | EMPLOYER | WORK PHONE NO ( )

GUARDIAN'S NAME: FIRST | MIDDLE | LAST | RESPONSIBLE FOR PAYMENT? Y ☐ N ☐

ADDRESS: NUMBER & STREET | APT# | CITY | ST | ZIP | COUNTRY

HOME PHONE NO ( ) | MOBILE PHONE NO ( ) | EMAIL ADDRESS | EMPLOYER | WORK PHONE NO ( )

INSURANCE INFORMATION

IS YOUR VISIT RELATED TO: ☐ WORKER'S COMPENSATION? ☐ AUTOMOBILE ACCIDENT? IF SO, PLEASE COMPLETE BACK OF FORM

EFFECTIVE DATE: | PRIMARY INSURANCE

ADDRESS | PHONE NO ( )

GROUP # | POLICY# | POLICY HOLDERS NAME | RELATIONSHIP TO PATIENT

DATE OF BIRTH ______________________ SEX: Male ☐ Female ☐ | SOCIAL SEC # | SUBSCRIBER EMPLOYER INFO

SECONDARY INSURANCE

ADDRESS | PHONE NO ( )

GROUP # | POLICY# | POLICY HOLDERS NAME | RELATIONSHIP TO PATIENT

DATE OF BIRTH ______________________ SEX: Male ☐ Female ☐ | SOCIAL SEC # | SUBSCRIBER EMPLOYER INFO

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: FIRST | INITIAL | LAST

HOME PHONE NO ( ) | WORK PHONE NO ( ) | RELATIONSHIP TO PATIENT

OTHER INFO

SECOND HOME ADDRESS | DATES THERE | HOME PHONE NO ( )

OTHER PHYSICIAN ADDRESS: | CITY/STATE | PHONE NO ( )

REFERRING PHYSICIAN

PHYSICIAN NAME: | PHONE NO ( )

ADDRESS: NUMBER & STREET | CITY | ST | ZIP

NEW PATIENT REGISTRATION **(PLEASE PRINT)** **DATE:**

COMPLETE **ONLY** IF RELATED TO AN AUTOMOBILE ACCIDENT

Date of Accident: ______________________________

AUTOMOBILE INSURANCE COMPANY

Name: ______________________________

Address: ______________________________

Subscriber Name & Relationship: ______________________________

Policy Number: ______________________________

Claim Number: ______________________________

Patient's Complaint: ______________________________

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COMPLETE **ONLY** IF RELATED TO A WORKMANS COMPENSATION CLAIM

Date of Accident: ______________________________

EMPLOYER AT TIME OF INJURY

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

CARRIER (INSURANCE COMPANY)

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Claim Number: ______________________________

Patient's Complaint: ______________________________

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