

New Patient Registration

PATIENT INFORMATION

_____ / ____ / ____
 Last Name First Name Middle Initial DOB MM/DD/YYYY

 Address/Apt/Suite City State Zip Code

(____) _____ - _____ (____) _____ - _____ _____ @ _____
 Home Phone Mobile Phone Email

DEMOGRAPHICS

Race
 American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Gender
 Male Female
 Other _____

Ethnicity
 Hispanic or Latino Non-Hispanic or Non-Latino

Preferred Language

CARE TEAM

Primary Care Physician (PCP) _____

Emergency Contact

_____ (____) _____ - _____
 Last Name First Name Relationship Preferred Phone

Responsible Party/Guarantor

_____ / ____ / ____ (____) _____ - _____
 Last Name First Name Relationship DOB MM/DD/YYYY Preferred Phone

 Address/Apt/Suite City State Zip Code

Visit Information

Reason for Visit _____ Preferred Pharmacy(Incl. Location) _____

Payment Source Uninsured/Self-Pay Primary Insurance Secondary Insurance Employer: _____

Primary Insurance Company: _____ Insurance Card Avail Not Avail (Fill out Information)

 Insurance Plan Policy #/Subscriber ID Group #

Insurer Same as Patient Same as Guarantor Other (Fill out Information)

_____ / ____ / ____
 Last Name First Name Relationship DOB MM/DD/YYYY

How Did You Hear About Us?

<input type="checkbox"/> Billboard	<input type="checkbox"/> Drove by Center/Sign	<input type="checkbox"/> Google	<input type="checkbox"/> Physician Referral
<input type="checkbox"/> Center Website	<input type="checkbox"/> Employer	<input type="checkbox"/> Hospital	<input type="checkbox"/> Radio
<input type="checkbox"/> Community Event	<input type="checkbox"/> Existing Patient	<input type="checkbox"/> Music Streaming (Spotify)	<input type="checkbox"/> Social Media
<input type="checkbox"/> Direct Mail	<input type="checkbox"/> Family or Friends	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Yelp
			<input type="checkbox"/> Other _____