
# 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?** _____



Revised: 06/20/18