New Patient Form

NEW PATIENT REGISTRATION FORM

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible. If you have any questions, please contact the office. Thank you and we look forward to seeing you!

PATIENT INFORMATION

First Name

Middle Initial

Last Name

Date of Birth

SSN

Sex

Mailing Address

City

State

Zip Code

Cell Phone

Home Phone

Email Address

ADDITIONAL INFORMATION

Race (choose one)

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Hispanic

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Other

☐ Decline

Ethnicity (choose one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Decline

Preferred Language

Emergency Contact Name

Emergency Contact Number

Who is your Primary Care Provider (PCP)?

RESPONSIBLE PARTY

Primary Insurance Name

Policy ID

Group ID

Policy Holder's Name

Policy Holder's DOB

Policy Holder's SSN

Patient Relationship to Policy Holder (choose one)

☐ Self ☐ Dependent ☐ Spouse

☐ Other

SECONDARY INSURANCE INFORMATION

Secondary Insurance Name

Policy ID

Group ID

Policy Holder's Name

Policy Holder's DOB

Policy Holder's SSN

Patient Relationship to Policy Holder

MEDICAL HISTORY

Please list all medications you are currently taking (including over the counter and vitamins/supplements)

Please list any allergies

Please check all that apply

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Seizure
- ☐ Mental
- ☐ Asthma
- ☐ Depression
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Cancer
- ☐ None

Type of Cancer
(If Applicable)

Other
(If Applicable)

SOCIAL HISTORY

Do you smoke? (choose one)

- ☐ No
- ☐ Yes
- ☐ Occasionally

How many cigarettes per day?
(If Applicable)

Any other forms of tobacco? (choose one)

☐ No ☐ Yes ☐ Occasionally

List
(If Applicable)

Do you drink alcohol? (choose one)

☐ No ☐ Yes ☐ Occasionally

How often?
(If Applicable)

Do you use any illicit drugs? (choose one)

☐ No ☐ Yes ☐ Occasionally

List
(If Applicable)

FAMILY HISTORY

Does anyone in your family (living or deceased) have the following:

Please check all that apply

☐ High Blood Pressure ☐ High Cholesterol ☐ Cancer

☐ Stroke ☐ Heart Disease ☐ Diabetes

☐ Depression ☐ Mental Illness ☐ Hypothyroidism

Other

SURGICAL HISTORY

Please select/list all surgeries:

Please check all that apply:

- ☐ Appendix
- ☐ Tonsils/Adenoids
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ C-Sections
- ☐ Heart

Other