# NEW PATIENT REGISTRATION FORM

Please complete all sections. Fields marked with * are required.

## SECTION 1: PATIENT INFORMATION

Today's Date:* _____

Last Name:* _____ First Name:* _____

Middle Initial: _____ Gender:* ☐ Male ☐ Female ☐ Other

Date of Birth:* (MM/DD/YYYY) _____ SSN: _____

Street Address:* _____

Apt/Unit: _____ City:* _____

State:* _____ ZIP Code:* _____

Home Phone: _____ Cell Phone:* _____

Email Address:* _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

### EMERGENCY CONTACT INFORMATION

Emergency Contact Name:* _____

Relationship:* _____ Phone:* _____

## SECTION 2: INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Insurance Company Name: _____

Policy/ID Number: _____ Group Number: _____

Subscriber Name (if not patient): _____

Subscriber Date of Birth: _____



*Please continue to next page*

## SECTION 3: MEDICAL HISTORY

Please check ALL that apply to you or a family member:

- ☐ Heart Disease/Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Diabetes (Type 1 or 2)
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Allergies (specify below)
- ☐ Cancer (specify type)
- ☐ Hepatitis A/B/C
- ☐ HIV/AIDS
- ☐ Tuberculosis (TB)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Arthritis/Joint Problems
- ☐ Artificial Joints
- ☐ Blood Disorders
- ☐ Bleeding Problems
- ☐ Currently Pregnant

**List ALL current medications (include vitamins, supplements, over-the-counter):**

**List ALL allergies (medications, foods, latex, etc.):**

Primary Care Physician Name: _____

Physician Phone: _____ Last Visit Date: _____



*Please continue to next page*

## SECTION 4: CONSENT AND AUTHORIZATION

**CONSENT FOR TREATMENT:**
I consent to the diagnostic procedures and treatment by the healthcare providers and staff at this facility. I understand that the practice of medicine and healthcare is not an exact science and acknowledge that no guarantees have been made to me regarding the outcome of treatments or procedures.

**FINANCIAL RESPONSIBILITY:**
I understand that I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all co-payments, deductibles, and non-covered services at the time of service.

**INSURANCE AUTHORIZATION:**
I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to the healthcare provider for services rendered.

**PRIVACY PRACTICES:**
I acknowledge that I have been offered a copy of the Notice of Privacy Practices, which describes how my medical information may be used and disclosed.

**ACCURACY OF INFORMATION:**
I certify that the information provided on this form is true and complete to the best of my knowledge. I will notify the healthcare provider of any changes to my medical status, medications, or contact information.

### PATIENT/GUARDIAN SIGNATURE:

Signature: _____ Date: _____

Printed Name: _____

*If signed by guardian/representative, please state relationship to patient:*

Relationship: _____

### FOR OFFICE USE ONLY

Received by: _____ Date: _____ Time: _____

Verified by: _____ Insurance Verified: Yes ■ No ■

Notes: _____



**Thank you for completing this form. Please return to reception.**