New Patient Paperwork

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #

Birth Sex ☐ M ☐ F	Primary Care Provider ☐ None

Mailing Address	Apt. #	City	State	Zip

Email Address	Home Phone	Cell Phone

Employer	Work Phone

Preferred Language	**RACE** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino	

EMERGENCY CONTACT	Name	Relationship	Primary Phone

Guarantor (Person responsible for payment)

Guarantor's Name	Guarantor Birth Date	Guarantor Social Security #

Preferred Pharmacy

Pharmacy Name			Pharmacy Address
City	State	Zip	Pharmacy Phone No.

Insurance | Please present your ID and insurance card to the receptionist.

PRIMARY INSURANCE CARRIER	**SECONDARY INSURANCE CARRIER**
Insurance Company Name	Insurance Company Name
Address	Address
City / State / Zip	City / State / Zip
Phone / Policy Number	Phone / Policy Number
Group Number / Name	Group Number / Name
Insured Name & DOB	Insured Name & DOB
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent