.Please Print

Today's Date		☑ Please check the box next to all phone numbers, addresses and email addresses which are confidential. The check means you give us permission to send healthcare information such as test results to those addresses or leave it on your voicemail.

PATIENT INFORMATION

Full Legal Name (Last)	(First)	(Middle)	Name Normally Used (Nickname)
Date of Birth	Age	Gender	
Home Phone ☐	Work Phone (including extension) ☐		Cell Phone ☐
Address (Number) ☐	(Street)	(Apt. No.)	
City	State		Zip
How Did You Hear About Us?			

GUARANTOR'S INFORMATION

Full Legal Name (Last)	(First)	(Middle)	**Do you have legal custody? Y N**
Patient's relationship to guarantor			Date of Birth
Address (If Different From Above) ☐			
City	State		Zip
Home Phone ☐	Work Phone (including extension) ☐		Cell Phone ☐

CONTACT INFORMATION

Name of guardian			Relationship to patient
Home Phone ☐	Work Phone (including extension) ☐		Cell Phone ☐
Address (If Different From Above) ☐			
City	State	Zip	Email address ☐

ALTERNATE CONTACT INFORMATION

Name			Relationship to patient
Home Phone ☐	Work Phone (including extension) ☐		Cell Phone ☐
Address (Number) ☐	(Street)	(Apt. No.)	
City	State	Zip	Email address ☐

EMERGENCY INFORMATION

Person to Notify in Case of Emergency		Relationship
Home Phone ☐	Work Phone (including extension)	Cell Phone ☐

For appointment reminders do you prefer ☐ Text Message ☐ Email ☐ Voicemail

☑ **Don't forget to check all confidential numbers and addresses above.**

Signature _____ SS# (required)_____

Print Name _____ Relationship _____

New Patient Registration Form

NAME: _____ BIRTHDATE: _____ DATE: _____

How much did your child weigh at birth? _____

How many weeks before birth? (If not known, write full term, early, or late) _____

Born naturally or C-section? _____ Hepatitis B given in hospital? (Y / N)

How long was your child in the hospital after birth? _____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

_____

ALLERGIES: _____ SENSITIVITIES: _____

_____ _____

List SURGERIES you have had (include reason and year): _____

_____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include reason and year): _____

_____

_____

_____

Who in your *FAMILY* has/had (circle if cause of death and write age of death)

heart disease _____ genetic disorder _____

diabetes _____ cancer _____

seizure _____ high cholesterol _____

mental illness _____ sudden death _____

bleeding disorders _____ asthma _____

allergies _____ stomach problems _____

tuberculosis _____ high blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

_____

Who lives in your household? _____

_____

Do you have any pets? _____

Does anyone smoke? If so, please list what type, how much, and how often. _____

Do your children go to daycare? _____

Please sign and date: _____