New Patient Information Form

What is the reason for your visit today? **Today's Date**

Patient Information
Name (Last, First, MI)

Address | City | State | ZIP Code

Telephone xxx-xxx-xxxx | Ok to Leave Message? ☐Yes ☐No | Marital Status | Birthdate xx/xx/xxxx

Email | Social Security # | Birth Gender ☐M ☐F | Age

Employer (or parent/guardian employer if patient is a minor | Work Phone xxx-xxx-xxxx | Preferred Language

Primary Care Provider (where you go for routine medical care) | Referring Physician

Emergency Contact Name | Emergency Contact Phone # | Relationship to Patient

Medical Insurance (please present your ID and insurance card to the receptionist

PRIMARY Insurance Company Name | Policy Number/Member ID | Group Number

Insured Name | Insured Birthdate xx/xx/xxxx | Patient relationship ☐Self ☐ Spouse ☐Dependent

Insurance Company Address (usually on back of insurance card) | Phone xxx-xxx-xxxx

SECONDARY Insurance Company Name | Policy Number/Member ID | Group Number

Insured Name | Insured Birthdate xx/xx/xxxx | Patient relationship ☐Self ☐ Spouse ☐Dependent

Insurance Company Address (usually on back of insurance card) | Phone xxx-xxx-xxxx

Guarantor/Responsible Party (person responsible for payment

Legal Name of Responsible Party (First Middle Last) | Social Security # | Birthdate xx/xx/xxxx

Preferred Pharmacy Name | Pharmacy Location | Pharmacy Phone

Authorization to Pay Benefits to Provider

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