New Patient Information

Patient Name_____ Marital Status: S M D W
Last First MI
Date of birth_____ Social Security number_____
Address: _____Apt#_____
City_____ State_____ Zip_____
Phone: Home_(_____)_____
Cellphone_(_____)_____
Work_(_____)_____
Email Address: _____

Employer:_____Occupation: _____

Spouses Name or Parent Name, if child:_____
Is this the person responsible for the bills? O Yes O No, bill patient
Address, if different than patient_____
Date of birth:_____ Employer:_____
Work Phone(_____)_____Cell(_____)_____ SS#_____

Race: O White O Other or mixed Gender: O Male O Female
O Black O Asian
O American Indian or Alaska Native Ethnicity: O Hispanic or Latino
O Native Hawaiian or other Pacific Islander O Not Hispanic or Latino

Preferred language: O English O other_____

Would you like to be reminded of upcoming office visits? O Yes O No
If so, which method do you prefer? O Home Phone O Cell Phone O Work Phone
(Check all that apply) O Mail O Email
May we leave a message (voice-mail) for you regarding test results, reminders, etc.? O Yes O No
If so, which method do you prefer? O Home Phone O Cell Phone O Work Phone
(Check all that apply) O Mail O Email
Do you have an Advance Directive (Living Will)? O Yes O No
(If yes, please provide our office with a copy for your records at your earliest convenience.)

Please list your medical insurance company(companies)
1._____Insured_____Policy#_____Grp#_____
2._____Insured_____Policy#_____Grp#_____
3._____Insured_____Policy#_____Grp#_____