New Patient Registration Form

Reason for visit:
Duration of symptoms (i.e. hours, days):
Is this work related? [Yes] [No]
Are you allergic to any medications? [Yes] [No] If so, which ones?
List your daily medications & dosage:

Patient Information:

Name:	Date of Birth:	Sex: [Male] [Female]
Address: Apt:		Marital Status:
City/State:	Zip:	Primary Language:
Home #:	Cell #:	SSN #:
Employer:	Work #:	
Email:		
Circle to which we may leave a message: [Home] [Cell] [Work]		

Legal Guardian / Responsible Party (for minors):

Name:	Date of Birth:	Sex:	SSN #:
Address:	Relationship:		
City/State/Zip:	Home #:		Cell #:

Insurance Information:

Primary Subscriber:	Date of Birth:	SSN #:
Secondary Subscriber:	Date of Birth:	SSN #:

Preferred Pharmacy:

Name:	
Address:	City/State/Zip:
Phone #:	Fax #:

Primary Care Provider Information:

Name:	
Phone #:	Fax #:

Emergency Contact Information:

Name:	Phone #:	Relationship:

Demographics / General Information:

Race: [American Indian or Alaskan Native] [Asian] [Native Hawaiian or Pacific Islander] [Black or African American] [Hispanic] [White] [Other:] [Refuse / Decline to State]
Ethnicity: [Hispanic or Latino] [Not Hispanic or Latino] [Refuse / Decline to State]
How did you hear about us?: [Internet Search] [Referred by family or friend] [Referred by Physician or Physician Office] [Referred by Local Business] [Referred by Hotel] [Magnet Mailer] [Urgent Care website] [Drove by or saw a sign] [Insurance] [Magazine] [Newspaper] [School] [Insurance] [Decline to State]