NEW PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE	PREFERRED NAME
RESIDENCE ADDRESS		CITY STATE ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
MAILING ADDRESS (if different from residence)		CITY STATE ZIP	
EMAIL ADDRESS		MARITAL STATUS	
BIRTH DATE	SEX	SSN	SPOUSE/ PARTNER'S NAME
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE H: W:	EMERGENCY CONTACT RELATIONSHIP	
EMPLOYER NAME	EMPLOYMENT STATUS	EMPLOYER ADDRESS	

RESPONSIBLE PARTY IF THE PATIENT IS UNDER 18 YEARS OLD.

LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO PATIENT
ADDRESS		CITY STATE ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
EMPLOYER NAME	EMPLOYMENT STATUS	EMPLOYER ADDRESS	

PHYSICIAN INFORMATION

PRIMARY CARE PROVIDER:	PCP PHONE:
REFERING PROVIDER (if you were referred to us by another doctor)	

AUTHORIZATION

It is our responsibility to protect your medical records and we do not provide any information regarding you or your medical conditions without your written consent. Please list below any other healthcare providers or anyone else with whom we may discuss your medical conditions and medical bill.

NAME	RELATIONSHIP	CAN DISCUSS MY: ☐ Medical history ☐ Medical bill
NAME	RELATIONSHIP	CAN DISCUSS MY: ☐ Medical history ☐ Medical bill
NAME	RELATIONSHIP	CAN DISCUSS MY: ☐ Medical history ☐ Medical bill

PHONE CALLS/MESSAGES

We often call patients for the reasons listed below. Please mark which number we may call to leave messages.

Is it OK to leave a message to confirm your appointment?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it OK to leave a message with results of lab or imaging studies?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it OK to MAIL the results of lab or imaging studies to your home address?

☐ Yes ☐ No

INSURANCE

Who is to be billed for today's visit?

☐ INSURANCE ☐ SELF ☐ LABOR & INDUSTRIES* ☐ MOTOR VEHICLE INSURANCE* ☐ 3RD PARTY INSURANCE*

*PLEASE FILL IN THE INFORMATION IN THE "MOTOR VEHICLE INSURANCE / LABOR & INDUSTRIES / THIRD PARTY" SECTION ON THE NEXT PAGE

PRIMARY			
	INSURANCE COMPANY NAME	POLICY NUMBER	RELATIONSHIP TO INSURED
	SUBSCRIBER NAME	SUBSCRIBER SEX	SUBSCRIBER DATE OF BIRTH
	INSURANCE BILLING ADDRESS (Usually located on back of card)		INSURANCE PHONE NUMBER
	GROUP EMPLOYER NAME		GROUP NUMBER

SECONDARY			
	INSURANCE COMPANY NAME	POLICY NUMBER	RELATIONSHIP TO INSURED
	SUBSCRIBER NAME	SUBSCRIBER SEX	SUBSCRIBER DATE OF BIRTH
	INSURANCE BILLING ADDRESS (Usually located on back of card)		INSURANCE PHONE NUMBER
	GROUP EMPLOYER NAME		GROUP NUMBER

ADDITIONAL DEMOGRAPHIC INFORMATION

PRIMARY LANGUAGE

SPOKEN:
- ☐ ENGLISH
- ☐ INDIAN (incl. Hindi & Tamil)
- ☐ RUSSIAN
- ☐ SPANISH
- ☐ OTHER: _______________

WRITTEN:
- ☐ ENGLISH
- ☐ INDIAN (incl. Hindi & Tamil)
- ☐ RUSSIAN
- ☐ SPANISH
- ☐ OTHER: _______________

RACE
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HISPANIC OR LATINO
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ WHITE OR CAUCASIAN
- ☐ MORE THAN ONE OF THE ABOVE
- ☐ PREFER NOT TO DISCLOSE

ETHNICITY
- ☐ HISPANIC
- ☐ NON-HISPANIC
- ☐ PREFER NOT TO DISCLOSE

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ONE)
- ☐ PERSONAL REFERRAL (FRIEND, FAMILY, ANOTHER PATIENT)
- ☐ INSURANCE COMPANY PROVIDER LIST OR WEBSITE
- ☐ COMMUNITY EVENT OR LOCAL CHAMBER MEETING
- ☐ MAGAZINE AD (SPECIFY): ______________________________
- ☐ NEWSPAPER AD (SPECIFY): _____________________________
- ☐ RADIO COMMERCIAL (SPECIFY): _________________________
- ☐ TV COMMERCIAL
- ☐ PROVIDER (SPECIFY): ________________________________
- ☐ MAILER
- ☐ TRANSIT AD
- ☐ INTERNET AD
- ☐ FACEBOOK AD
- ☐ CINEMA AD
- ☐ PHONEBOOK
- ☐ PHARMACY BAG
- ☐ EMPLOYER HEALTH FAIR