PRACTICE NAME

ADDRESS, TELEPHONE AND FAX

BEFORE YOUR FIRST VISIT

New Patient Registration

PATIENT INFORMATION

FULL LEGAL NAME

DATE OF BIRTH

HOME ADDRESS

PREFERRED PHONE

EMAIL

PREFERRED PHARMACY

PREFERRED LANGUAGE

EMERGENCY CONTACT

CONTACT NAME

RELATIONSHIP

PHONE

REASON FOR VISIT

- ☐ New patient wellness exam
- ☐ Acute illness or injury
- ☐ Chronic condition follow-up
- ☐ Sports or school physical

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT

HOW DID YOU HEAR ABOUT US

- ☐ Referral from another patient
- ☐ Referring physician
- ☐ Insurance directory
- ☐ Online search

By signing below you confirm the information above is accurate to the best of your knowledge. Clinical history and medications are collected separately at check-in, not on this form.

PATIENT (OR GUARDIAN) SIGNATURE

DATE