

# NEW PATIENT REGISTRATION FORM

<b>PATIENT DEMOGRAPHICS</b>	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:
REFERRING 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: <input type="checkbox"/> Medical history <input type="checkbox"/> Medical bill
NAME	RELATIONSHIP	CAN DISCUSS MY: <input type="checkbox"/> Medical history <input type="checkbox"/> Medical bill
NAME	RELATIONSHIP	CAN DISCUSS MY: <input type="checkbox"/> Medical history <input type="checkbox"/> 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\*     
  3<sup>RD</sup> PARTY INSURANCE\*

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

<b>PRIMARY</b>	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

<b>SECONDARY</b>	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:		WRITTEN:	
<input type="checkbox"/> ENGLISH	<input type="checkbox"/> INDIAN (incl. Hindi & Tamil)	<input type="checkbox"/> ENGLISH	<input type="checkbox"/> INDIAN (incl. Hindi & Tamil)
<input type="checkbox"/> RUSSIAN	<input type="checkbox"/> SPANISH	<input type="checkbox"/> RUSSIAN	<input type="checkbox"/> SPANISH
<input type="checkbox"/> OTHER: _____		<input type="checkbox"/> OTHER: _____	
RACE		ETHNICITY	
<input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE	<input type="checkbox"/> ASIAN	<input type="checkbox"/> HISPANIC	<input type="checkbox"/> NON-HISPANIC
<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> HISPANIC OR LATINO	<input type="checkbox"/> PREFER NOT TO DISCLOSE	
<input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	<input type="checkbox"/> WHITE OR CAUCASIAN		
<input type="checkbox"/> MORE THAN ONE OF THE ABOVE	<input type="checkbox"/> PREFER NOT TO DISCLOSE		
HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ONE)			
<input type="checkbox"/> PERSONAL REFERRAL (FRIEND, FAMILY, ANOTHER PATIENT)	<input type="checkbox"/> INSURANCE COMPANY PROVIDER LIST OR WEBSITE	<input type="checkbox"/> MAILER	<input type="checkbox"/> TRANSIT AD
<input type="checkbox"/> COMMUNITY EVENT OR LOCAL CHAMBER MEETING	<input type="checkbox"/> MAGAZINE AD (SPECIFY): _____	<input type="checkbox"/> INTERNET AD	<input type="checkbox"/> FACEBOOK AD
<input type="checkbox"/> NEWSPAPER AD (SPECIFY): _____	<input type="checkbox"/> RADIO COMMERCIAL (SPECIFY): _____	<input type="checkbox"/> CINEMA AD	<input type="checkbox"/> PHONEBOOK
<input type="checkbox"/> TV COMMERCIAL	<input type="checkbox"/> PROVIDER (SPECIFY): _____	<input type="checkbox"/> PHARMACY BAG	<input type="checkbox"/> EMPLOYER HEALTH FAIR