



NEW PATIENT REGISTRATION FORM

Confidential | Accurate Information Helps Us Provide the Best Care

1 PATIENT INFORMATION

Full Legal Name: _____

Preferred Name: _____

Date of Birth: _____

Pronouns (optional): _____

Address: _____

City / State / ZIP: _____

Phone (Primary): _____

Phone (Secondary): _____

Email: _____

Preferred Contact Method: _____

2 MARITAL STATUS & HOUSEHOLD

☐ Single ☐ Divorced ☐ Widowed

☐ Married

Who do you live with: _____

Children (names/ages): _____

3 EMPLOYMENT & EDUCATION

☐ Employed ☐ Unemployed ☐ Retired

☐ Self-Employed

Employer / School: _____ ☐ Student ☐ Other

Occupation: _____

Highest Level of Education: _____

4 EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

Alternate Phone: _____

5 PRIMARY CARE PROVIDER

Provider Name: _____

Practice Name: _____

Phone / Fax: _____

Address: _____



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6 PHARMACY INFORMATION

Preferred Pharmacy: _____

Address: _____

Phone: _____

Alternate Pharmacy (if applicable): _____

7 INSURANCE INFORMATION

Primary Insurance: _____

Member ID / Group #: _____

Policyholder Name: _____

Policyholder DOB: _____

Relationship to Patient: _____

Secondary Insurance (if applicable): _____

8 REFERRAL SOURCE

☐ Primary Care Provider

☐ Therapist/Counselor

☐ Family or Friend

☐ Insurance Provider

☐ Social Media

☐ Search Engine

☐ Community Event

☐ Other

9 CONSENT TO CONTACT

I consent to routine appointment reminders, billing, and general practice communications using the methods checked.

☐ Phone Call

☐ Text Message

☐ Email

☐ Patient Portal

10 ACKNOWLEDGMENT & SIGNATURE

I certify that the information provided is true and accurate to the best of my knowledge and will notify the practice of material changes.

Patient Name (Print): _____

Signature: _____

Date: _____