



New Patient

Today's Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Address: _____
Street
City
State
Zip

Female Male Marital Status: _____ SS#: _____

Birth Date: ____/____/____ Referring or Primary Care Doctor: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

In Case of Emergency Contact: _____
Name
Relationship
Phone

RESPONSIBLE PARTY (if patient is a minor) or if insured information different from patient:

Full Name: _____ Birth Date: ____/____/____

SS#: _____

Please circle the answer that best applies:

<p><u>Race:</u></p> <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Native Asia <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Patient Decline	<p><u>Ethnic:</u></p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Patient Decline	<p><u>Smoker:</u></p> <input type="checkbox"/> Current, Every Day <input type="checkbox"/> Current, Some Days <input type="checkbox"/> Former <input type="checkbox"/> Never <input type="checkbox"/> Former, Current <input type="checkbox"/> Unknown	<p><u>Primary Language:</u></p> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Dutch <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese
--	--	---	---

How do you prefer to be reminded about future appointments? Phone Text Email

Office use only: Email access