New Patient Registration

Confidential patient information. Complete all applicable fields.

PATIENT INFORMATION

Legal first name

Legal last name

Preferred name

Date of birth

Pronouns (optional)

Marital status (optional)

Street address

City

State / ZIP

Mobile phone

Alternate phone

Email address

CONTACT PREFERENCES

- [ ] Phone call permitted
- [ ] Voicemail permitted
- [ ] Text message permitted
- [ ] Email permitted
- [ ] Use discreet practice name in messages
- [ ] Do not identify the nature of the appointment in messages

Preferred contact method and best time

EMERGENCY CONTACT

Name

Relationship

Telephone

Alternate telephone

REFERRAL & VISIT

New Patient Registration

Confidential patient information. Complete all applicable fields.

How did you hear about us?

Primary reason for consultation

SIGNATURE

Printed name

Date

Signature (sign after printing or use an approved e-signature workflow)

By signing, I confirm that I reviewed this form and that the information I provided is accurate to the best of my knowledge.