CHART #: ___________

New Patient Form - Demographics

Patient Name: ____
Last First MI

Date of Birth: _____-_____-_____ SS#: ______-______-______ Marital Status: ______________

Address: ____________________________________ City: _________________ State: _____ Zip: _______

Home Phone: __________________ Cell Phone: _______________ Work Phone: _______________

Email: ____

Primary Care Physician: _______________________ Referring Physician: _______________________

Federal Government Required Fields

Sex: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ American Indian/ AK Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

If patient is a minor: ____________________________ _______________ _____________
Parent/Guardian Name DOB Phone

Emergency Contact: ____________________________ _______________ _____________
Name Relation Phone

____ ___________________________
SIGNATURE of PATIENT or GUARDIAN or POWER OF ATTORNEY DATE

CHART #: ___________

New Patient Form - Insurance

Do you plan to file Workman's Compensation Claim? ☐ **Yes** ☐ **No**

Workman's Compensation

Name of WC Insurance Carrier: ____

WC Carrier Address: ____

Employer: _________________________ Case Worker: _________________________

Claim Number: ______________________ Phone & Fax Case Worker: _______________

Date of Injury: ___________________________ Is this visit authorized? ☐ Yes ☐ No

Would you like us to bill your personal health insurance? ☐ **Yes** ☐ **No**

Personal Health Insurance Responsible Party/ Policy Holder

Name: _____________________________ DOB: _____________SSN: ________________

Patient Relationship to Policy Holder: ____________________

Primary Insurance

Primary Insurance Company: ____

Ins Company Address: ____

Policy #: _________________ Group #: ____________ Effective Date: ___________

Secondary Insurance

Secondary Insurance Company: ____

Ins Company Address: ____

Policy #: _________________ Group #: ____________ Effective Date: ___________

____ ______________________

SIGNATURE of PATIENT or GUARDIAN or POWER OF ATTORNEY DATE

CHART #: ___________

New Patient Form - Medications

PATIENT NAME: ____ DOB: _____-_____-_____
LAST FIRST MI

PHARMACY: _______________________________ Location: ______________________________

VITAL SIGNS Height: _______ Weight: ________

MEDICAL HISTORY

Medications Currently Taking ☐ Currently not taking any medication

Medication & Dose	Medication & Dose

Medication Allergies ☐ No Known Drug Allergies

Medication Allergy/ Reaction

Non-Medication Allergies ☐ None

(Mark if you have the following non-medication allergies)

Food: ☐ Eggs ☐ Yeast

Contact: ☐ Iodine ☐ Latex ☐ Metal ☐ Tape ☐ Other

Contrast Agent – Dye Allergy: ☐ Yes ☐ No ☐ Don't Know

____ ___________________________
SIGNATURE of PATIENT or GUARDIAN or POWER OF ATTORNEY DATE