

Form 06001: New Patient Registration

Please Print

Today's Date					
PATIENT INFORMATION					
Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)	
Address (Number)		(Street)		(Apt. No.)	
City		State	Zip	Social Security No.	Home Phone
Date of Birth		Age	Sex	Marital Status	Occupation
Employer Name		Employer Street Address		City	State Zip
Business Phone (Including Extension)			Patient's Driver's License No.		State
Other Physicians You See					
How Did You Hear About Us?					
Name of Your Preferred Pharmacy		Preferred Pharmacy Address		Preferred Pharmacy Phone#	Preferred Pharmacy Fax#
SPOUSE'S INFORMATION					
Full Legal Name (First) (Middle) (Last)				Occupation	
Address (If Different From Above)		City		State	Zip Home Phone
Employer Name	Street Address		City	State	Zip Business Phone (Ext)
INSURANCE INFORMATION					
Primary Insurance Company Name			Group No.	ID/Certificate No.	
Subscriber Name AND DATE OF BIRTH			Where to Send Claim		
Secondary Insurance Company Name			Group No.	ID/Certificate No.	
Subscriber Name					
Other Insurance Information					
EMERGENCY INFORMATION					
Person to Notify in Case of Emergency				Relationship	
Address (Number)		(Street)		(Apt. No.)	
City			State	Zip	Home Phone
INFORMATION FOR THE PATIENT					
<ol style="list-style-type: none"> 1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc. 2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office. 3. If you have any questions we will, of course, be happy to assist you. 					