New Patient Pre-Registration

Full Legal Name: ________________________ Preferred Name: ________________________

Date of Birth: ________________ Gender: ________________ Pronouns: ________________

Mailing Address: ____

City: ________________ State: ________________ Zip Code: ________________

Email: ________________________________ SSN: ________________

Cell Phone: ________________ Home Phone: ________________ Work Phone: ________________

Preferred Phone: ☐ Cell ☐ Home ☐ Work Initial to consent to leave a detailed message: ________

Primary Insurance Information

Insurance Name: ____

Identification Number: ________________________ Group Number: ________________________

Name of Insured Party: ________________________ Relationship to Patient: ________________

Sex (Required for billing purposes): ☐ M ☐ F Insured Party Date of Birth: ________________

Secondary Insurance Information

Insurance Name: ____

Identification Number: ________________________ Group Number: ________________________

Name of Insured Party: ________________________ Relationship to Patient: ________________

Sex (Required for billing purposes): ☐ M ☐ F Insured Party Date of Birth: ________________

Current Medications (Please note, we do not routinely prescribe most long-term, controlled medications.)

Medication	Dose	Time/Day

Signature: ____ Date: ________________