



NEW PATIENT INFORMATION

Please print and complete all entries

Patient Name (Last, First & Middle Initial)	Address
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City, State	ZIP	Home Phone	Cell Phone
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Email: _____

Patient Date of Birth	Patient SSN	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married Other _____
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Race: White Black or African American American Indian or Alaska Native Asian
 Native Hawaiian or Other Pacific Island Patient Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient Declined

Gender Identity: Male Female Transgender Gender Queer Other Choose not to answer

Sexual Orientation: Straight or Heterosexual Lesbian, gay or homosexual Bisexual Something Else
 Don't know Choose not to answer

Veteran Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Non Veteran	Schooling: <input type="checkbox"/> High School <input type="checkbox"/> College _____ <input type="checkbox"/> No formal schooling <input type="checkbox"/> Other _____
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Agricultural Work Status: <input type="checkbox"/> Non agricultural <input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant <input type="checkbox"/> Retired Farm Worker	Homeless: <input type="checkbox"/> Street <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional <input type="checkbox"/> Doubling Up <input type="checkbox"/> Other _____
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Do you have a Primary Care Doctor? Yes No Who? _____

Patient Employer Name	Patient Employer Address (Street, City, State & ZIP)	Employer Phone
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Insured/Responsible Party Information	Relation to patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
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Insured Name (First, Last and Middle Initial)	Address (If different than patient – Street, City, State & ZIP)
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Home Phone	Work Phone	SSN	Birth Date	Employer
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Insurance Information

Primary Insurance Name	Address (Street, City, State & ZIP)	Phone
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Group Number	ID Number	Employer	Employer Phone
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Secondary Insurance Name	Address (Street, City, State & ZIP)	Phone
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Group Number	ID Number	Employer	Employer Phone
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Emergency Contact:
Name: _____ Relationship: _____ Phone Number: _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Signature (Patient or, if minor signature of parent or guardian)	Date
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