



New Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ **SSN:** _____ Preferred Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Gender assigned at birth: Male Female Gender Identity: _____

Do you have a latex allergy? **Yes** **No** Preferred Pronouns: _____

Preferred Language: _____ Any difficulty seeing or hearing? _____

Emergency Contact: _____

Relationship: _____ Phone: _____

If you would like to list anyone as an Authorized Contact, allowing them to schedule/cancel appointments, receive and discuss billing and insurance information, or receive medical treatment or health updates, please request an **Authorized Contact Form** at the front desk.

Is this visit due to an accident? **Yes** **No**

If yes, please circle: Worker's Compensation Auto Third-Party Liability

_____ **Please initial that you have received the HIPAA information.**

Due to HIPPA and confidentiality requirements, please read and check the appropriate places.

It is ok to leave messages regarding my appointments on my:

Home Cell Voicemail

Is there anyone you do not want us to leave a message with regarding appointments: Yes No

If yes, please list the individual(s): _____

Patient Signature: _____ Date: _____

Patient Guardian Signature: _____ Date: _____