NEW PATIENT CHECK-IN

NAME:		DATE SEEN:	
Date of Birth :	Age:	Nickname:	Gender :
Street Address :		Insurance :	
City, State, Zip :		Soc Security # :	
Home Phone :		Marital Status :	
Work Phone :		Primary Clinic :	
Cell Phone :		Occupation :	
Email Address :		Employer :	

Best daytime phone # to reach you? Home_____ Work_____ Cell_____

How do you prefer to be contacted about future appointments? ___Email ___Text ___ Call Cell ___Call Home ___Mail

How did you hear about us? ___Friend/Family ___Doctor Referral ___Angie's List ___Internet Search ___Phone Book ___Insurance Company/Their Website ___Other____________________________

HEALTH CARE REFORM INFORMATION	
What type of address is the above?	Home___ Vacation Home___ Mailing___ Temporary___ Other________
What is your primary language?	English___ Spanish___ Russian___ Other____________
Do you have any special needs that we should know in order to better serve you?	Hearing Impaired___ Wheelchair___ Translator___ None___
What race do you consider yourself?	American Indian/Alaska Native_____ Asian_____ Black/African American____ Native Hawaiian/Pacific Islander_____ White_____ Decline to Answer_____
What is your ethnicity?	Not Hispanic/Latino_____ Hispanic/Latino_____ Decline to answer_____

ACCOUNT RESPONSIBILITY - if patient is a minor or has a POA		
Party Responsible :	SSN:	Relationship :
Address :		
Home # :	Work # :	Email :

TWO EMERGENCY CONTACTS

Last	First	Relationship	Home#	Work#	Cell#

Patient/Representative **Signature** | **Print** name if other than Patient | **Relationship** to Patient