NEW PATIENT REGISTRATION FORM

Last Name: ________________________ **First Name:** _____________________ **Middle Name:** ___________________

Preferred Name: ____ **Date of Birth:** ___________________________

Birth Sex: ☐ Female ☐ Male ☐ Undifferentiated **Social Security #:** ________________________________

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other (specify): ___________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partnership

Street Address/P.O. Box: ____ **Apartment #:** ________

City: ____ **State:** _________ **Zip:** ______________

Home Phone: (_____)____________________ **Cell Phone:** (_____)_______________________

Email Address: ____**Preferred Language:** _________________________

Do you need translation services? ☐ Yes ☐ No **Do you have an advanced directive?** ☐ Yes ☐ No

Race: ☐ Asian (specify):_____________ ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Pacific Islander (specify):_______________ ☐ More Than One Race ☐ Decline To State

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino ☐ Decline To State

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Other (specify): ______________________ ☐ Don't Know ☐ Decline To State

Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Transgender Male/Transgender Man/Transmasculine ☐ Transgender Female/Transgender Woman/Transfeminine ☐ Other (specify): ___________ ☐ Decline To State

Emergency Contact
Name: ________________________________ **Relationship:** ____________ **Phone:** (_____)_____________________

Preferred Pharmacy: _______________ **Pharmacy Address:**____

Insurance: ___________________ **Policy #:** __________________ **Policy Holder Name:**______________________
Secondary Insurance: ________________ **Policy #:** _______________ **Policy Holder Name:** ____________________
Policy Holder Date of Birth: ______________________

Primary Care Provider (Current/Previous)

Name: ____ **Phone:** _____________________________

Address: ____

Housing Status:
☐ Not Homeless ☐ Homeless Shelter ☐ Transitional Housing ☐ Doubling Up ☐ Street ☐ Permanent Supportive Housing ☐ Other ☐ Unknown

Are you a seasonal or migrant worker? ☐ No ☐ Seasonal ☐ Migrant

Are you a veteran? ☐ No ☐ Yes

Do you have a physical or mental disability? ☐ No ☐ Yes

Do you have substance abuse, including but not limited to alcohol, tobacco, opioids, illicit drugs? ☐ No ☐ Yes

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Please answer the following as accurately as possible. This information allows us to provide you services at the lowest cost possible.

Family size: ________________________ Monthly Household Income: _____________________________

FOR MINORS (LESS THAN 18 YEARS OLD) ONLY :

Parent/Legal Guardian Name: __________________________________ **Date of Birth:** ________________________
Address: ____ **Relationship to Minor:** _______________
Phone: (_____)_______________________

Parent/Legal Guardian Name: __________________________________ **Date of Birth:** ________________________
Address: ____ **Relationship to Minor:** _______________
Phone: (_____)_______________________

ALL OTHER DOCTORS/SPECIALISTS/PROVIDERS WHO PARTICIPATE IN YOUR CARE:

Provider Type/Specialist	Provider Name
___________________________	_______________________________________
___________________________	_______________________________________
___________________________	_______________________________________
___________________________	_______________________________________

ALLERGIES

Drug Allergy	Reaction	Non-Drug Allergy	Reaction
____________________	______________	___________________	__________
____________________	______________	___________________	__________
____________________	______________	___________________	__________
____________________	______________	___________________	__________
____________________	______________	___________________	__________

MEDICAL & FAMILY HISTORY (Check all that apply)

	You	Father	Mother	Sibling	Other: ___________
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Cancer: ______________	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes - Type 1	☐	☐	☐	☐	☐
Diabetes - Type 2	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Urinary Problems	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐
Liver Problems	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Prostate Problems	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐

Other: ____

MEDICATIONS (May list below or bring in bottles)

Medication Name	Dose	Frequency
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________
____________________________________	_______________	_______________

SURGICAL HISTORY

Procedure	Approximate Date
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

SOCIAL HISTORY

☐ **Tobacco**	Packs per day:	Duration:	Quit date:	
☐ **Smokeless Tobacco**	Uses per day:	Duration:	Quit date:	
☐ **Illicit Drugs**	Type:	How often:	Duration:	Quit date:
☐ **Marijuana**	Form:	How often:	Duration:	Quit date:
☐ **Alcohol**	Drinks per week:	Duration:	Quit date:	

VACCINES (List approximate date last received)

Pneumonia ______________________________

Shingles ______________________________

Tetanus/TDAP ______________________________

Flu ______________________________

HPV ______________________________

COVID-19 ______________________________

Monkeypox ______________________________

Hepatitis A ______________________________

Hepatitis B ______________________________

SCREENING TESTS (List approximate date last performed)

Mammogram ______________________

Pap Smear ______________________

Bone Density ______________________

Lung Cancer Scan ______________________

Colonoscopy ______________________

Abdominal Aneurysm ______________________