

NEW PATIENT REGISTRATION / UPDATED INFORMATION



Patient's Legal Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):
Patient's Legal Guardian (if patient is a minor or legally dependent):		Relationship:	
What brings the patient here for care today?: <input type="checkbox"/> Switching primary care providers <input type="checkbox"/> Seasonal/temporary care (i.e., Winter Texan, other, etc.) <input type="checkbox"/> Bariatric / Weight Management Only		If the patient is here for seasonal care or weight management only, who is his/her regular PCP (and location if not local)?	
Patient's Mailing Address:			
Patient's Physical Address:			<input type="checkbox"/> Same as Mailing Address
Patient's Personal Cell Phone Number:			<input type="checkbox"/> Leave a voicemail with detailed information <input type="checkbox"/> Leave a message with call back number only
Patient's Email Address:		How did you hear about us?	

Patient's Social Security Number:	Patient's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Patient's Employer:	Patient's Occupation:
Which best describes the patient's race? <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline	Is the patient of Hispanic/Latino ethnic descent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline

Emergency Contact Information I authorize this person to be contacted in the event of an emergency or in the event the clinic cannot get ahold of the patient for an urgent/important matter:		
Emergency Contact Name	Phone Number	Relationship to Patient
May we discuss medical information with the above contact ONLY in the event of an emergency situation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Hospital

Authorized Contacts for Medical & Billing Information I authorize the following person(s) to access the patient's medical and/or billing information:			
Authorized Contact 1	Name:		Phone Number:
	Relationship to Patient:	May we discuss medical information with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No May we discuss billing information with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Authorized Contact 2	Name:		Phone Number:
	Relationship to Patient:	May we discuss medical information with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No May we discuss billing information with this person? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby verify that all information on this form is true and correct to the best of my knowledge.

Signature of Patient, Parent, or Legal Guardian	Relationship to Patient	Date
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