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**NEW PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(If different)

Phone: Primary \_\_\_\_\_ Secondary \_\_\_\_\_  
(Best place to reach you)

May we leave messages at either number?                    **YES**    **NO**

If not, where would you like us to leave a message? \_\_\_\_\_

Patient's Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Person responsible for your account \_\_\_\_\_

Relationship to you \_\_\_\_\_

Social Security # of Responsible Party \_\_\_\_\_

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Relationship status:    Single                    Married                    Partnered                    Widowed

Name of Spouse/Partner (parents/guardian for minor) \_\_\_\_\_

Children & Ages (siblings for minor) \_\_\_\_\_

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Name of primary care physician \_\_\_\_\_

Phone \_\_\_\_\_

In case of emergency notify \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Referred by \_\_\_\_\_

**I attest to the accuracy of the information provided above.**

\_\_\_\_\_  
Patient or (Authorized Parent/Guardian Name) **Print**

\_\_\_\_\_  
Patient or Authorized Parent/Guardian **Signature**

\_\_\_\_\_  
**Date Signed**