[Your firm name and logo]

[Practice name] | [Address] | [Phone]
NEW PATIENT INFORMATION
Appointment date: [MM/DD/YYYY] | Provider: [Clinician name]

About you
Legal name: [ ] Preferred name: [ ] Date of birth: [ ] Sex: [ ] Address: [ ] Mobile phone: [ ] Email: [ ] Preferred language: [ ] Interpreter needed: [ ] yes [ ] no. May we leave messages by voicemail [ ] text [ ] email [ ]?

Emergency contact
Name: [ ] Relationship: [ ] Phone: [ ]

Insurance
Primary plan: [Carrier] Member ID: [ ] Group number: [ ] Subscriber name and date of birth: [ ] Your relationship to the subscriber: [ ]. Secondary plan, if any: [Carrier, member ID, subscriber]. Person responsible for the bill, if not you: [Name, phone, address].

Reason for today's visit
Main concern: [ ] When did it start? [ ] Referred by: [Name and phone] Primary care provider: [Name and phone]

Medications and allergies
List every medication, vitamin and supplement with dose and how often you take it: [ ]. Pharmacy name and phone: [ ]. Allergies to drugs, foods or latex, and the reaction: [ ].

Health history
Check any that apply: [ ] diabetes [ ] high blood pressure [ ] asthma or lung disease [ ] heart disease [ ] cancer [ ] thyroid disease [ ] other: [ ]. Surgeries and hospital stays, with years: [ ]. Conditions in parents or siblings: [ ]. Tobacco, alcohol and other substance use: [ ].

Women's health module (optional)
Could you be pregnant? [ ] yes [ ] no. Date of last menstrual period: [ ]. Pregnancies and births: [ ].

Pediatric module (optional)
Birth history and any complications: [ ]. School and grade: [ ]. Immunizations up to date: [ ] yes [ ] no; please bring the record.

People we may talk to about your care
You may share information about my care with: [Name, relationship, phone]. I can change this list at any time.

Financial policy and consent to treat
I have read the financial policy, I assign insurance benefits to [Practice name], and I consent to examination and treatment by its clinicians.

Acknowledgment of receipt of the Notice of Privacy Practices (separate page)
I acknowledge that I received [Practice name]'s Notice of Privacy Practices on [MM/DD/YYYY]. Signature: _____ Printed name: _____. Office use, if not signed: staff note of the

good-faith effort to obtain this acknowledgment and the reason it was not obtained: _____

Signature of patient, parent or guardian: _____ Date: [MM/DD/YYYY]
If signing for the patient, relationship: [ ]