HEALTH FIRST

New Patient Registration

PATIENT INFORMATION

_____ _____ _____ ____/____/_____
Last Name First Name Middle Initial DOB MM/DD/YYYY

_____ _____ _____ _____
Address/Apt/Suite City State Zip Code

(_____) _____-_____ (_____) _____-_____ _____@_____
Home Phone Mobile Phone Email

DEMOGRAPHICS

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Gender
☐ Male ☐ Female
☐ Other_____

Ethnicity
☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Preferred Language
_____

CARE TEAM

Primary Care Physician (PCP) _____

Emergency Contact
_____ _____ _____ (_____) _____-_____
Last Name First Name Relationship Preferred Phone

Responsible Party/Guarantor
_____ _____ _____ ____/____/_____ (_____) _____-_____
Last Name First Name Relationship DOB MM/DD/YYYY Preferred Phone

_____ _____ _____ _____
Address/Apt/Suite City State Zip Code

Visit Information

Reason for Visit _____ **Preferred Pharmacy(Incl. Location)**_____

Payment Source ☐ Uninsured/Self-Pay ☐ Primary Insurance ☐ Secondary Insurance ☐ Employer: _____

Primary Insurance Company: _____ ☐ Insurance Card Avail ☐ Not Avail (Fill out Information)

_____ _____ _____
Insurance Plan Policy #/Subscriber ID Group #

Insurer ☐ Same as Patient ☐ Same as Guarantor ☐ Other (Fill out Information)
_____ _____ _____ ____/____/_____
Last Name First Name Relationship DOB MM/DD/YYYY

How Did You Hear About Us? _____

Revised: 06/20/18