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## **NEW PATIENT INFORMATION FOR MEDICAL RECORDS**

**\*ALL INFORMATION IS REQUIRED**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SEX: \_\_\_\_\_ M \_\_\_\_\_ F SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

RACE: \_\_\_\_\_ AMERICAN INDIAN \_\_\_\_\_ ASIAN \_\_\_\_\_ BLACK/AFRICAN AMERICAN \_\_\_\_\_ DECLINED \_\_\_\_\_ NAT. HAWAIIAN/PACIFIC  
ISLANDER \_\_\_\_\_ UNKNOWN \_\_\_\_\_ WHITE \_\_\_\_\_ OTHER \_\_\_\_\_

DOES THE PATIENT SMOKE? \_\_\_\_\_ YES \_\_\_\_\_ NO DOES THE PATIENT DRINK ALCOHOL? \_\_\_\_\_ YES \_\_\_\_\_ NO

RESPONSIBLE FOR PATIENT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CELL #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ HOME #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please indicate which, if any, number is "okay" to leave confidential information: ☐ C ☐ H ☐ W

EMAIL: \_\_\_\_\_ PREFERRED COMMUNICATION: \_\_\_\_\_

PREFERRED PHARMACY CONTACT INFO: \_\_\_\_\_

WHO MAY WE THANK FOR YOUR REFERRAL? \_\_\_\_\_

### **PRIMARY INSURANCE:**

INSURANCE NAME: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE TELEPHONE NUMBER: \_\_\_\_\_

SUBSCRIBER ID # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

DOB: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

### **SECONDARY INSURANCE:**

INSURANCE NAME: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURANCE TELEPHONE NUMBER: \_\_\_\_\_

SUBSCRIBER ID # \_\_\_\_\_

GROUP # \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

DOB: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

### **EMERGENCY CONTACTS:**

NAME: \_\_\_\_\_ CONTACT #: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ CONTACT #: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**Credit / debit card information is required for cancellation purposes, phone consultations, shipping & handling of orders and outstanding balances in account.**

CARD TYPE: \_\_\_\_\_ VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ AMERICAN EXPRESS \_\_\_\_\_ DISCOVER

CARD HOLDER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

CARD NUMBER: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_ SECURITY CODE: \_\_\_\_\_

**I certify to my best of my knowledge the above information is correct. I hereby consent to Medical and Osteopathic Treatment by Rachel West, DO and office staff.**

**There is a 48 hour cancellation policy. Appointments not cancelled within 48 hours or no-shows to their scheduled appointment will inquire a \$100 charge on their credit/ debit card.**

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: \_\_\_\_\_