Rachel West, D.O
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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 NAME: _____
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: _____