**NEW PATIENT INFORMATION FORM Appt Req Date (& time):**

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| --- | --- |
| PATIENT’S NAME |  |
| **Optional**: DOES PATIENT HAVE A NICKNAME/PREFERRED NAME? |  |
| GENDER & DATE OF BIRTH |  |
| PATIENT’S HOME ADDRESS |  |
| BEST PHONE NUMBER:CELL OR LANDLINE? (If cell, do they have a home/landline?) | BEST: HOME/OTHER:  |
| BEST EMAIL ADDRESS |  |
| PRIMARY CARE PHYSICIAN / WHERE LOCATED (City, State) |  |
| **Optional**: REFERRING PHYSICIAN -- (if different from PCP) WHERE LOCATED (City, State) |  |
| MOTHER’S NAME (CONFIRM FIRST & LAST) |  |
| FATHER’S NAME (CONFIRM FIRST & LAST) |  |
| FATHER’S BEST CONTACT PHONE (WORK OR CELL)(for emergency purposes) |  |
| REASON FOR VISIT/CHIEF COMPLAINT: |  |
| DOES PATIENT LIVE WITH BOTH PARENTS?(if not, with whom does child reside?) |  |
| **Optional**: ANY RESTRICTIONS ON NON-CUSTODIAL PARENT? |  |
| PRIMARY INSURANCE (company) |  |
| TYPE OF PLAN (HMO/PPO/etc.) |  |
| **Optional:** IS THE PLAN IN A NARROW NETWORK (HMO only) |  |
| POLICY NUMBER OR ID NUMBER |  |
| GROUP NUMBER (if any) |  |
| WHO IS THE PRIMARY SUBSCRIBER? |  |
| PRIMARY SUBSCRIBER’S DATE OF BIRTH |  |
| IS THERE A SECONDARY INSURANCE? (If so, include details) |  |
| ADDITIONAL NOTES, IF NEEDED |
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