New Patient Information Form

Date

PATIENT INFORMATION

Patient's Last Name | ☐ Male ☐ Female | Patient's First Name | Preferred Name | Middle Initial

Date of Birth | SSN# | Primary Language

Marital Status | Race/Ethnicity

Email Address

Address | City & State | Zip Code

Cell Phone | Home Phone | Is patient of Hispanic Origin? ☐ YES ☐ NO

PARENT INFORMATION *(if patient is under 18)*

Last Name | First Name | Middle Initial

Address *if different than above | City & State | Zip Code

Cell Phone | Date of Birth | SSN#

EMERGENCY CONTACT

Please provide an Emergency Contact:

Name | Phone | Relation to Patient

EMPLOYMENT

Name of Employer | Address | Phone

INSURANCE INFORMATION **Please present your insurance card to the front desk staff member.*

Name of Insurance Company | Name of Subscriber | Effective Date

Group Number | Subscriber Number | Insured Date of Birth

MEDICARE SUPPLEMENT **Please present your insurance card to the front desk staff member.*

Name of Insurance Company | Name of Subscriber | Effective Date

Group Number | Subscriber Number | Insured Date of Birth

HOW DID YOU HEAR ABOUT APEX?