New Patient Registration & Medical Intake

Please complete this form to provide your demographic, health history, and consent information as a new patient. All information is confidential.

Patient Demographic Information

Tell us about yourself.

Full Name *

Date of Birth (MM/DD/YYYY) *

Phone Number *

Email Address

Street Address *

City, State, ZIP *

Gender *

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

Emergency Contact Information

Who should we contact in an emergency?

Emergency Contact Name *

Relationship to Patient *

Emergency Contact Phone Number *

Insurance Details

Your insurance information helps us process your visit.

Insurance Company Name

Insurance Policy Number

Primary Care Provider Information

Let us know your main healthcare provider.

Primary Care Provider Name

Primary Care Provider Phone/Contact

Reason for Visit

Tell us why you are seeking care today.

What is the primary reason for your visit? *

Medical & Surgical History

Please answer the following about your health history.

Have you ever had any of the following medical conditions? (Check all that apply)

- ☐ Diabetes
- ☐ Hypertension (high blood pressure)
- ☐ Heart Disease
- ☐ Asthma
- ☐ Cancer
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Other

Please list any surgeries you have had (including year, if known):

Family History

Does anyone in your family have any of the following? (Check all that apply)

Family History of:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Cancer
- ☐ Other

If you selected any above, please specify relation and condition:

Social History

Your lifestyle and habits.

Do you currently use tobacco products?

- ◯ Yes
- ◯ No

Do you currently use alcohol?

- ◯ Yes
- ◯ No

Do you use recreational drugs?

- ◯ Yes
- ◯ No

If yes to any above, please specify type and frequency:

Current Medications

List all prescription and over-the-counter medications you are currently taking.

Please list all current medications (name, dose, frequency):

Allergies

Please list any allergies (medications, foods, environmental, etc.).

Do you have any allergies? *

- Yes
- No

If yes, please specify all allergies and reactions:

Immunization Status

Tell us about your immunizations.

Are your immunizations up to date?

- Yes
- No
- Not sure

Please list any recent or important immunizations (e.g., flu, COVID-19, tetanus):

Review of Systems

Please check any symptoms you are currently experiencing.

Current Symptoms (check all that apply):

- ☐ Fever
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Rash
- ☐ Fatigue
- ☐ Headache
- ☐ Other

Consent & Acknowledgments

Please read and acknowledge the following.

I understand that the information provided is accurate to the best of my knowledge and consent to treatment. *

- ☐ I agree and consent