New Patient Registration

Patient Information

Name:
Sex: male female
Date of birth (mm/dd/year):

Marital status: single married
divorced widowed
Address:

Please fill out all and then circle your preferred contact method below.

Email:
Daytime telephone:

Cell phone:
Evening telephone:

Emergency Contact Information

Name:
Relationship to patient:

Daytime telephone:
Evening telephone:

Primary Care Physician

Name:
Telephone:

Address:

Referral

Do you have a referral from your doctor? ❑yes (if yes, complete line below)
❑no (if no, skip line below)
Authorization number: _____
Number of visits authorized:_____

Health Insurance Information

Primary insurance:
Telephone:
Insurance ID number:
Group number:
Policy holder's name:
Policy holder's date of birth (mm/dd/year):

Policy holder's address:

Policy holder's relationship to patient: ❑self ❑parent ❑spouse ❑other:
Co-pay amount $

Authorization
❑ I authorize Alexis M Beck, MPH, RD, LDN to speak with and disclose my protected health information with the above named primary care physician.

❑ I authorize _____ to speak with and disclose my protected health information with the above named primary physician.
Signature: _____
Date:_____

Parent/legal guardian signature is required for any patient under 18 years of age.
Printed name:
Signature: Date: