



New Patient Information Form

Date _____

PATIENT INFORMATION

Patient's Last Name	<input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cell Phone		Home Phone		Is patient of Hispanic Origin?

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
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EMPLOYMENT

Name of Employer	Address	Phone
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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?