NEW Health

REGISTRATION FORM (PLEASE FILL OUT COMPLETELY)

Patient Information			
Last Name:	First Name:	MI:	DOB: / /
Physical Address:			
Mailing Address:			
Social Security #	Marital Status:	Preferred Pharmacy:	
Home #	Mobile #	Email:	
Preferred Contact Method: ☐ Text ☐ Email ☐ Phone	Sex Assigned at Birth: ☐ Male ☐ Female		
RESPONSIBLE PARTY *Complete if someone other than the patient			
Last Name:	First Name:	MI:	DOB: / /
Physical Address:			
Phone #	Email:	Relationship to Patient:	
MEDICAL INSURANCE INFORMATION			
Subscriber Name:	Relationship to patient:	DOB: / /	
Primary Medical Insurance:			
Member ID #	Group #	Effective Date: / /	
DENTAL INSURANCE INFORMATION			
Subscriber Name:		DOB: / /	
Primary Dental Insurance:			
Member ID #	Group #		

To comply with requirements regarding federal record-keeping & reporting, we ask that you complete the following data. YOUR COOPERATION IS APPRECIATED		
Primary Language: ☐ English ☐ Spanish ☐ Other:		Interpreter Needed? ☐ Yes ☐ No
Family Size:	Estimated annual household income: $	Are you a Veteran? ☐ Yes ☐ No

Ethnicity	**Race**		**Special Population**
☐ Hispanic (Latino)	☐ White	☐ Black (African American)	☐ Migrant Worker
☐ Non-Hispanic (Latino	☐ Asian	☐ American Indian/ Alaska Native	☐ Seasonal Worker
☐ Unreported/Refused	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Homeless
	☐ Unreported	☐ Multiracial – Select 2	☐ Public Housing

Health Insurance Portability & Accountability Act (HIPAA)/ Privacy Policy		
Please list the names of persons authorized by you to receive your health information, pick up medication, or copies of personal paperwork. ***Note: Photo ID and signature required by person picking up medications or copies of other information***		
Name:	**Phone #:**	**Relationship:** ☐ Parent/ Guardian ☐ Spouse ☐ Other:
Name:	**Phone #:**	**Relationship:** ☐ Parent/ Guardian ☐ Spouse ☐ Other:

EMERGENCY CONTACT		
Name:	**Phone #:**	**Relationship:** ☐ Parent/ Guardian ☐ Spouse ☐ Other:

****Please check each item below. Sign and date at the bottom****

ACKNOWLEDGEMENT AND AUTHORIZATION:

☐ I have read and understand the HIPAA/Privacy Policy for NEW Health.

Scan QR code to read the document:

☐ I have read and understand the Appointment Policy for NEW Health.

Scan QR code to read the document:

☐ I accept financial responsibility for services I receive, and I hereby assign my insurance benefits to be paid directly to NEW Health.

☐ I authorize NEW Health to release medical/dental information required to process my claim.

☐ I authorize NEW Health to obtain/have access to my medication, vaccine, and health history.

☐ I authorize my provider's office to contact me by mobile phone, including text messaging.
We call or send texts/emails regarding your appointments, updates, financial balances, surveys, and newsletters approximately 1-2 per week. You can change your contact preferences at any time either by text, email, online or by contacting the clinic. You are responsible for any text or data charges that may occur.

☐ I authorize NEW Health to mail or leave detailed messages regarding appointment and/or lab results with the individual answering my home number or voicemail system.

☐ I authorize my provider's office to obtain my photograph for proof of identity.

By signing this form, I certify that the information provided is correct and I authorize NEW Health to provide treatment for care.

Signature:_____ Date:_____

How did you hear about us?

☐ **Social Media** ☐ **Radio** ☐ **Newspaper** ☐ **Referral** ☐ **Billboard** ☐ **Word of Mouth**