Confidential New Patient Form

Full Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

Employer Address: _____ Job Title: _____

Marital Status (circle one): Married Single Widowed Divorced

Name/ages of children: _____

Spouse's Name: _____ Spouse's DOB: _____

Spouse Occupation: _____ Spouse Employer: _____

Email: _____

Gender* (circle one): Male Female

Ethnicity* (circle one): Hispanic/Latino Non-Hispanic/Latino I decline to answer

Race* (circle one): American Indian or Alaska Native / Asian / Black or African American /
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Smoking Status* (circle one): Every day smoker / Occasional smoker / Former smoker / Never Smoked

Smoking Start Date (Optional): _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Who referred you to our office? _____

Please circle the type of care you desire: Temporary relief / Long-term corrective / Dr. Recommendation

Preferred method of communication for patient reminders: Email / Phone / Mail

*Required per Federal Guidelines