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**New Patient Registration Form**

**Patient Information**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Sex: M / F \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status:      Married      Single      Divorced      Widowed

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_

Phone: \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we contact in case of an emergency? \_\_\_\_\_

Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Phone: \_\_\_\_\_

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**Insurance Information**

Responsible Party Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address (if different): \_\_\_\_\_

SSN: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**Primary Insurance**

Insurance Name: \_\_\_\_\_

Policy Holder Name / DOB: \_\_\_\_\_

Group No: \_\_\_\_\_ Policy No: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Insurance**

Insurance Name: \_\_\_\_\_

Policy Holder Name / DOB: \_\_\_\_\_

Group No: \_\_\_\_\_ Policy No: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize Wake Family Medicine or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date