

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

Task: Fill in a new patient form with your information.

**New Patient Health Form**

Title Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Dr. \_\_\_\_\_

\_\_\_\_\_  
First Name Middle Initial Last Name

\_\_\_\_\_  
Date of Birth MM/DD/YY Citizenship

\_\_\_\_\_  
Address City

\_\_\_\_\_  
Postal Code Phone Number

**Emergency Contact**

\_\_\_\_\_  
Name Phone Number

\_\_\_\_\_  
Relationship

**Do you have medical insurance?    \_\_\_ Yes    \_\_\_ No**

**Do you have any allergies? If yes, what are they?**

\_\_\_\_\_  
**Do you take any medication? If yes, list below.**

\_\_\_\_\_  
**Do you smoke?    \_\_\_ Yes    \_\_\_ No**

**Do you drink alcohol?    \_\_\_ Yes    \_\_\_ No**

**Authorization**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date