

Name: _____

Date: _____

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

NEW PATIENT HEALTH FORM

Personal Information:

Title: Mr. _____ Mrs. _____ Ms. _____ Dr. _____

First Name Middle Initial Last Name

Date of Birth: MM/DD/YY Preferred Language

Address City Postal Code

Telephone Number Email Address

Emergency Contact Information:

Name Phone Number Relationship

Do you have medical insurance? Yes _____ No _____

Health Information:

Do you smoke? Yes ____ No ____

Do you drink alcohol? Yes ____ No ____

Do you have any allergies? Yes ____ No ____ If yes, what are they?

Do you take medication? Yes ____ No ____ If yes, please list below:

At the moment, do you have any symptoms? Yes ____ No ____

If yes, what are they? Please list:

How long have you felt these symptoms?

Patient's Signature:
