MANHATTAN MEDICAL GROUP

New Patient Form

_____
Today's Date

Personal Information

Name (first, middle, last)	Gender ☐ Male ☐ Female ☐ Other
Mailing Address (street/PO box)	Date of Birth
City, State, Zip	
Preferred Phone ☐ Home ☐ Cell ☐ Work	Social Security Number
Race ☐ White ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other _____	Ethnicity ☐ Hispanic ☐ Non-Hispanic
Would you like to enroll in our patient portal (including online bill pay, emailed appointment reminders, etc.)? ☐ Yes ☐ No	Email Address
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____	Language ☐ English ☐ Spanish ☐ Other _____
Previous/Referring Primary Care Provider & Phone Number	
How did you hear about us? ☐ Google ☐ Friend/Family Member ☐ Free Screening/Community Event ☐ Radio/TV ☐ Facebook ☐ Physician Referral _____ ☐ Mail/Postcard ☐ Newspaper/Magazine ☐ Other _____	

Responsible Party

Please only complete this section if the patient is a minor.

Parent/Legal Guardian Name	Date of Birth
Mailing Address (street/PO box, city, state, zip)	Social Security Number
Preferred Phone ☐ Home ☐ Cell ☐ Work	Gender ☐ Male ☐ Female ☐ Other

Primary Insurance

Please give your insurance card and ID or driver's license to the receptionist.

Primary Insurance Name	Policy Number	Group Number
Subscriber Name		Subscriber DOB
Subscriber Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse		

Secondary Insurance

Secondary Insurance Name	Policy Number	Group Number
Subscriber Name		Subscriber DOB
Subscriber Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Spouse		

Approved Contacts

Keeping our patient's information private is important to us, and by default, we will only disclose information related to the patient's billing account and medical conditions to the patient or responsible party. Please indicate below to whom and how medical information should be disclosed to additional contacts. **One contact is required.**

Contact Name	Relationship to Patient
Contact Phone Number	☐ Billing Account ☐ Medical Condition ☐ Emergency Contact
Contact Name	Relationship to Patient
Contact Phone Number	☐ Billing Account ☐ Medical Condition ☐ Emergency Contact