New Patient Registration Form

Date___________________________

First name _______________________ Last name_______________________

Date of birth______________________

Mailing address: Street_____________________________ City_____________

State________________________________ Zip code____________________

Phone numbers: Home _____________________ Work ___________________

Cell ____________ Best # to leave a confidential message? Home Cell Work

Email address____

Emergency Contact: Name:_____________________ Relationship__________

Phone________________________

Who referred you to Innate Medicine?_____________________________

Do you have a primary care provider?

Name_____________________________ Phone #______________________

For purposes of lab and imaging testing, do you have health insurance?_______

If yes, name of carrier____

Notice of Privacy Practices (HIPAA): My signature below indicates that I have received the Notice of Privacy Practices of Innate Medicine MD

____ ______________________

Patient Signature: If other than patient, please print name: