New Patient Registration Form

Please complete this form and bring it with you to your first visit. For private records or sensitive information, contact the office for secure submission instructions.

PATIENT INFORMATION

Legal Name

Preferred Name

Date of Birth

Sex at Birth

Mobile Phone

Alternate Phone

Email Address

Preferred Language

Street Address

City / State / ZIP

Preferred Pharmacy

EMERGENCY CONTACT

Name

Relationship

Phone

Alternate Phone

INSURANCE INFORMATION

Primary Insurance Company

Member ID

Group Number

Policy Holder Name

Policy Holder Date of Birth

Relationship to Patient

VISIT INFORMATION

Primary reason for visit

Current concerns or questions for the doctor

New Patient Registration Form

CONSENT AND COMMUNICATION PREFERENCES

- [ ] Phone call
- [ ] Voicemail
- [ ] Text message
- [ ] Email for general non-sensitive reminders only
- [ ] Patient portal when available

People authorized to receive appointment or general account information

ACKNOWLEDGMENT

I certify that the information provided is accurate to the best of my knowledge. I understand Adams Internal Medicine may request additional information for care, billing, insurance verification, or secure records transfer.

Patient / Guardian Signature

Date

Printed Name