New Patient Registration Form

CONTINUUM
HEALTH CARE

Demographic Information

Full Legal Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: ( ) _____ Date of Birth: _____

Reason for Visit _____

Gender: ☐ Male ☐ Female

Billing Information

Financial Guarantor (Party responsible for billing) ☐ **Check if Self**

Full Legal Name: _____
Last *First* *M.I.*

Address: _____

Phone Number:

Insurance/ Medical Information

Primary Insurance Company:
Member ID:
Secondary Insurance Company:
Member ID
Preferred Pharmacy:
Name: _____
Address: _____
Phone: _____
Medication List (Please list all Current Medications Including Vitamins/Supplements)

Allergies: (Please include allergies such as Medication, food and others)

How did you hear about us?

☐ Internet ☐ Flyer ☐ Insurance

☐ Friend ☐ Driving By ☐ Other _____