Salei Primary Care Inc

New Patient Registration

Name:_____ Sex: M___ F___DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home:_____ Work: _____ Cell: _____

Email: _____

Race: White___ Black/African American ___ Latino ___ Asian ___ Native American ___ Other ___

Pharmacy: _____

Emergency Contact

Name:_____ Phone:_____

Address:_____ Relationship:_____

Insurance Information

Primary Insurance:_____

Policyholder's name:_____

Address (if different from above):_____

Secondary Insurance:_____

Policyholder's name:_____

Address (if different from above):_____

I do hereby agree and give my consent to the physician to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize a nurse to assist with my plan of care.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable