The Geraldine Clinic, LLC

New Patient Information Form

Legal Name:_____ _____ _____ _____Date: _____
(*First)* *(Middle)* *(Last)* *(Preferred)*

Birth date: ____-_____-_____ Social Security #: _____-_____-_____ Male/Female
Driver's License # _____ State: _____
Married:__ Single:___ Divorced:___ Widow:___
Address:_____ Suite/Apt: _____
City:_____ State:_____ Zip:_____
Phone: _____ _____ Pharmacy:_____
(Mobile) *(Home)*
Consent to text (circle one): Yes No

Name of Employer: _____N/A___ Employer Phone: _____ N/A___

Primary Language: _____ Race: _____ Ethnicity: _____

How did you hear about us (circle one) Advertisement Friend/Family Hospital Website Facebook Google Search
Other:_____

Patient Portal: A way of accessing personal medical information and communicating with the clinic.

Would you like to enroll (**CIRCLE ONE**) Yes No (if yes, please provide an email on line below)

The following is for the person responsible for payment: (will receive statements/bills)

Name:_____ _____ _____ _____ Self___ Spouse:____ Parent/Guardian:____
(*First)* *(Middle)* *(Last)* *(Preferred)*

Birth date: ____-_____-_____ Social Security #: _____-_____-_____
Phone: _____ _____ _____
(Mobile) *(Home)* *(Work)*

Email:_____
Address:_____ Suite/Apt: _____
City:_____ State:_____ Zip:_____

Insurance Information:

Insurance Plan Name: _____
Insurance telephone: _____ (usually on back of card)
ID/Contract #: _____ Group #: _____

IF PATIENT IS A MINOR: Please complete the following section:

Guardian :_____ _____ _____
(*First)* *(Middle)* *(Last)*

IN CASE OF EMERGENCY:

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____