2117 Bentley Plaza ● Fenton, MO 63026 ● Phone (636) 825-2200 ● Fax (636) 825-2201

New Patient Registration

PATIENT INFORMATION:

Patient Name: ______________________________ Date of Birth: ___________ SS#____________________

Mailing Address: ____

City/State:__________________________________ Zip: ___________

Male/Female/Other: _______________ Marital Status: Single / Married / Separated / Divorced / Widowed

Employer: _______________________________ Occupation: ________________________________

Phone: _________________________________ Cell Phone: _________________________________

Email address: ____________________________________ Primary Language: __________________________

Pharmacy Name: __________________________________ Pharmacy Phone Number: ____________________

INSURANCE INFORMATION:

Policy Holder's Name: ________________________________ Employer: __________________ DOB: ________

Primary Insurance Company: ___________________________ ID#: ______________ Group#:______________

Secondary Insurance Company: __________________________ ID#:______________ Group#:______________

EMERGENCY CONTACT:

Name:____________________________ Phone#:______________________ Relationship:__________________

Consent to Coordinate Care with Primary Care Physician

Name of Physician: ___________________________________ Phone Number: ___________________________

Address: __________________________________ City: __________________ State:_______ Zip: ___________

Signature of Patient/Guardian: ____ Date: __________________

CONSENT AND AUTHORIZATION:

I hereby give my consent and authorization for DELTA HEALTH to use or disclose my personal health information as they see fit. I understand that I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for DELTA HEALTH. I also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand that even though I have insurance, I am responsible for payment.

Patient/Guardian Signature: ____ Date: ____________________