HARBOR HEALTH, LLC
NEW PATIENT REGISTRATION

PATIENT INFORMATION

NAME: ____ DOB: _____________________
(FIRST) (MIDDLE) (LAST)

PREFERRED NAME/NICKNAME: _____________________ GENDER: _____ SS#: _______________________________

CONTACT INFORMATION (PLEASE CHECK OR CIRCLE PREFERRED CONTACT METHOD)

0 MOBILE PHONE: _________________________ 0 EMAIL: ____

0 HOME PHONE: __________________________ 0 WORK PHONE: ______________________

MAILING ADDRESS: ____

CITY: ________________________ STATE: ________ ZIP: ________________________

PAYMENT INFORMATION

0 SELF PAY 0 INSURANCE

INSURANCE: ______________________________ ID#: ________________________ GROUP: __________________

EFFECTIVE DATES: _____________________ SUBSCRIBER: _______________________________ DOB: _____________

GUARANTOR

PATIENT RELATIONSHIP TO GUARANTOR: 0 SELF 0 SPOUSE 0 CHILD 0 OTHER

GUARANTOR NAME: ____
(FIRST) (MIDDLE) (LAST)

ADDRESS: ____

CITY: __________________________________ STATE: __________ ZIP: ____________________

DOB: ___________ GENDER: ______ SS#: ____________________ PHONE: _________________________

PRESCRIPTIONS

PREFERRED PHARMACY: ______________________________________ CITY: ________________________

CURRENT MEDICATIONS (PRESCRIPTION, HERBALS/SUPPLEMENTS, AND OVER-THE-COUNTER: MAY CONTINUE ON ADDITIONAL PAGE.)

MEDICATION NAME	STRENGTH	WHEN TAKEN?	CONDITION	HOW LONG?

DEMOGRAPHICS

ETHNICITY/RACE: 0 AMERICAN INDIAN OR ALASKAN NATIVE 0 HISPANIC OR LATINO 0 ASIAN 0 WHITE

0 BLACK OR AFRICAN AMERICAN 0 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER 0 DECLINE

NEXT OF KIN

NEXT OF KIN NAME: ____
(FIRST) (MIDDLE) (LAST)

RELATIONSHIP: ____________________ PHONE: ______________________ 0 MOBILE 0 HOME 0 WORK

ADDRESS: __________________________________ CITY: _____________ STATE: _____ ZIP: ___________

Harbor health, LLC

Acknowledgement of privacy and financial policy

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Harbor health reserves the right to change the privacy policy as allowed by law.
- Harbor health has the right to restrict the use of the information but does not have to agree to those restrictions.
- I have the right to revoke this consent in writing at any time and all full disclosure will then cease.
- Harbor health may condition receipt for treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointment? Yes No

May we leave a message on your voicemail at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

*If yes, please name the members allowed:

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____

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I acknowledge that I have reviewed and received a copy of harbor health's financial and privacy policy

Signature ____ date: ____________

Witness:____ date: _____________