NEW PATIENT REGISTRATION FORM

Location: ❑ Lafayette ❑ Japan Town ❑ San Francisco

Today's date:	Primary Doctor:

PATIENT INFORMATION

Patient's Last Name: First: Middle Initial:	What is your gender identity? M F What sex were you assigned at birth? M F	What pronoun do you prefer?

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:

Mailing Address:	Social Security No.:	Home Phone No.: ( )

City:	State:	ZIP Code:	Cell Phone No.: ( )

Occupation:	Employer:	Employer's Phone No.: ( )

Referred to us by (PLEASE CHECK ONE) ❑ Dr. _____ ❑ Insurance Plan ❑ Family

❑ Friend ❑ Close to home/work ❑ Website ❑ Other

INSURANCE INFORMATION

(If you brought your insurance card please give your Insurance card/card's to the receptionist and skip this section.)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone No.: ( )

Occupation (if different):	Employer:	Employer address:	Employer Phone No.: ( )

Please indicate primary insurance:

Group #:

Policy#:

Co. Payment:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Bay Sports & Preventive Associate, Inc. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

West Coast Sports Institute (WCSI) HIPAA

Patient acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices of (**WCSI)**

I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my next appointment.

Patient Signature (if over 18)_____ Date: _____

Parent/Guardian Signature (if under 18)_____ Relationship to patient:_____

NEW PATIENT REGISTRATION FORM

Location: ❑ Lafayette ❑ Japan Town ❑ San Francisco

PATIENT INFORMATION

Name:	Date of Birth:

What name do you like to be called?	Would you like to sign up with our portal (Elation Passport)? ❑Yes ❑No	EMAIL: CELL NUMBER:

MEDICAL HISTORY

Have you ever been treated for any of the following medical conditions?

❑ No changes from previous ❑ Arthritis ❑ Diabetes ❑ High blood pressure ❑ Irritable bowel ❑ Osteoporosis	❑ Cancer ❑ Depression/anxiety ❑ Heart problems ❑ High cholesterol ❑ Lung problems ❑ Thyroid problems	Please list any additional medical conditions: _____ Have you ever been hospitalized overnight? ❑Yes ❑No Have you ever had surgery? ❑Yes ❑No (If yes, please list, or mark as unchanged) _____ ❑Unchanged from Previous

MEDICATIONS AND ALLERGIES

Do you take any medications regularly? ❑Yes ❑No If yes, please list:

Do you have any allergies to medications? ❑Yes ❑No If yes, please list:

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? ❑Yes ❑No If yes, Please list:

FAMILY HISTORY

Please list any known medical problems for the relatives listed below (For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis)

❑No changes from previous	Mother: _____
Father: _____	Brother/Sister: _____
Children: _____	Other: _____

Is there anything else we should know? _____