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New Patient Registration

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary phone number: _____ Ok to leave message? ☐

Alternate phone number: _____ Ok to leave message? ☐

Email address (optional): _____

Would you like online access to view your medical records? (Email address required for access) ☐

Would you like to receive appointment reminders through:

Phone call	☐
Email	☐
Text message	☐

Primary Care Provider (PCP): _____ PCP phone: _____

PCP address/location: _____

Emergency contact: _____

Address of Emergency contact: _____

Phone number: _____ Relationship to you: _____

Insurance company: _____ ID #: _____

If the policyholder is someone other than yourself, please fill out this section:

Name of policyholder: _____

Relationship of policyholder to you: _____ Birth date of policy holder_____

I hereby authorize Jeremy SantaCroce, RN/NP, LICSW to provide my insurance company with any information regarding treatment provided when so required. I authorize my insurance company to pay directly to Jeremy SantaCroce, RN/NP, LICSW all approved charges for services rendered and I understand my account will be credited upon receipt of payment.

_____ _____
Signature Date