Watertown FAMILY PRACTICE

New Patient Registration Form

Identification

Legal last name: _____

Legal first name: _____

First name used: _____

Middle name, suffix: _____

Previous name (last, first): _____

Legal sex: _____

DOB: _____

SSN: _____

Mother's maiden name: _____

Preferred name: _____

Contact

Address: _____

Address (ctd): _____

ZIP code: _____

City: _____

State: _____

Patient email: _____

Mobile phone: _____

Home phone: _____

Work phone: _____

Consent to receive Calls: ☐ Yes ☐ No

Consent to receive Texts: ☐ Yes ☐ No

Primary phone: _____

Emergency Contact

Name: _____

Emergency Contact (cont.)

Relationship: _____

Home phone: _____

Mobile phone: _____

Next of Kin

Name: _____

Relationship: _____

Phone: _____

Employment

Employer name: _____

Employer phone: _____

Usual occupation: _____

Usual industry: _____

Demographics

Language: _____

Race: _____

Ethnicity: _____

Marital status: _____

Sexual orientation: _____

Gender identity: _____

Assigned sex at birth: _____

Pronouns: _____

Homebound? ☐ Yes ☐ No

Provider Preference

Preferred provider: _____