ANKE OTT YOUNG, M.D.

Today's Date: ____/____/____

Account #

# NEW PATIENT REGISTRATION SHEET

**Patient Name:** ______________________________ **Date of Birth:** ______________ **Age:** ________

**Street Address:** ______________________________**City:** ______________**State:** ______ **Zip:** __________

**Telephone: Home:** __________________ **Cell:** __________________ **Work:**_________________ **SSN:** _________________

**Preferred Number:** ☐ **Home** ☐ **Cell** ☐ **Work** **Email:** ________________________________________

**Sex:** ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Other** ______________

**Emergency Contact: Name:** ________________________________ **Tel #:** ________________ **Relationship:** ___________

**Employment Status:** ☐ **Employed** ☐ **Student** ☐ **Retired** **If Employed: Position held:** __________________________

**Employer Name:** _____________________________________**Employer Location (City, ST):** _________________________

**Primary Care Physician: (Name):**____________________________________ **(Tel #):** _________________________

**Referred by: Physician (Name):** _____________________________________ **Referred by:** ☐ **Website**

**Family Member/Friend: (Name):**_____________________________________ ☐ **Other** _________________

**Preferred Pharmacy:** _______________________________________ **Address:** ____________________________________

**Pharmacy Phone:** ________________________________ **Town:** ______________________

| Primary Insurance Information | Secondary Insurance Information |
|---|---|
| **Name/Address/ Employer if different than patient** | **Name/Address/ Employer if different than patient** |
| **Ins Co. Name:** _____________________________________ | **Ins Co. Name:** _____________________________________ |
| **ID/ Member #:** ____________________________________ | **ID/ Member #:** ____________________________________ |
| **Group #:** __________________________________________ | **Group #:** __________________________________________ |
| **Policy Holder's Name:** ______________________________ | **Policy Holder's Name:** ______________________________ |
| **Address:** _________________________________________ | **Address:** _________________________________________ |
| **Date of Birth:** _____________________________________ | **Date of Birth:** _____________________________________ |
| **Employer:** _________________________________________ | **Employer:** _________________________________________ |

**If Patient is a minor (Under 18 Years Old)**

☐ **Check if address is same as patient**

**Parent/Guardian Name:** ________________________________**Relationship:** ☐ **Mother** ☐ **Father** ☐ **Other** __________

**Address:** _______________________________________**City/Zip:** ________________ **Date of Birth:**_________________

**Phone: Home:** _________________________ **Cell:** ____________________________ **Work:** _________________________

**Patient Name:** ____________________________________________________________ **Date of Birth** _________________