NEW HORIZON DIABETES CLINIC
PATIENT REGISTRATION

Date Today ____ /_____ /______

Patient Last Name	**First Name**	**Middle Initial**______ Suffix__ (Jr/Sr/II etc)
Date of Birth Month / Day / Year		SS#:
Address	City State	Zip
Patient E-mail Address		
Home Phone #: ( )	Cell Phone #: ( )	Message YES NO
Pharmacy Name	Pharmacy Address	Phone #: ( )
Primary Care Physician:	Referred By: (If Different From PCP)	

Gender: Male Female Unknow	**Preferred Language**: English Spanish Other ____________	
Race ☐ American Indian or Alaska Native ☐ Native Hawaiian or Another Pacific Islander ☐ Asian	☐ Black or African American ☐ White ☐ Patient declined to specify	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declined to specify
Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	**Spouse or Parent's name:**	

Authorization to Disclose Healthcare Information/ Emergency Contact

Name	Relationship	Phone
Diagnosis/treatment YES NO	Billing Info	YES NO

Subscriber / Responsible party information

Patient relationship to the responsible party: ☐ **SELF (same as above)**	☐ **Spouse** ☐ **Child** ☐ **Other**		
Name of Subscriber/Responsible Party:		DATE OF BIRTH: ______/_______/________	
Address:	City:	Zip Code:	State:
SS#: _____ - ______ - _____	Gender: ☐ Female ☐ Male	Phone #: ( ) _________-____________	

PATIENT INSURANCE INFORMATION ☐ **Self pay** ☐ **Primary Insurance Card Name** ☐ **Secondary Insurance Card Name**

Insurance Company Name's	
Employer:	Phone #: ( ) ________-___________

I authorize NHDC to release information on my care or treatment to my insurance, I also authorize payment be made to NHDC for services rendered. I understand I am responsible for any portion not paid by the insurance.

NHDC track missed (non-cancelled) appointments. A "**No Show/Late Cancellation**" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge for a missed or non-cancelled appointment. Insurance will not cover charges for no show/late or late cancellation fees. **The $50 charge** is in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointments may result in NHDC physician sending a letter discharging you from the practice.

_______________________________________ ____________________

Signature of patient or person authorized to sign for patient Date