# SANTA FE OB/GYN - New Patient Registration

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

| | | | | |
|---|---|---|---|---|
| Patient Name | Today's Date | Date of Birth | Sex | Age |
| Parent if Patient is a Minor | | | | |
| Patient's Social Security Number | | New Mexico Driver's License No. | | |
| Home Address | City | State | Zip | |
| Mailing Address if Different | City | State | Zip | |
| Home Telephone Number | Work Telephone Number | | Cellular Telephone Number | |
| Email address | | | | |
| Occupation | | Employer's Name | | |
| Employer's Address | City | State | Zip | |
| Spouse Name | | Employer | | |
| Other Physician's Name | | | | |
| Whom May We Thank for Referring You to Our Practice? | | | | |
| **NOTIFY IN CASE OF EMERGENCY** | | | | |
| Name | | Relationship | | |
| Address | City | State | Zip | |
| Home Telephone | Work Telephone | | Cell Telephone | |
| Nearest Relative (not living with you) | | | | |
| Home Telephone | Work Telephone | | Cell Telephone | |
| **FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES** | | | | |
| Name | | Telephone | | |
| Address | City | State | Zip | |
| Insurance Company | | Claim Address | | |
| Subscriber's Name | Subscriber's Date of Birth | | Subscriber's SSN#. | |
| Insurance ID No.: | | | | |
| Secondary Insurance | | Claim Address | | |
| Subscriber's Name | Subscriber's Date of Birth | | Subscriber's SSN# | |