New Patient Registration Form

Osteopathic Center for Family Medicine
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Please print clearly in ink. Fields marked * are required. You may also complete this enrollment online — ask us for a secure link.

Who are you enrolling?

☐ Individual ☐ Family *(complete the Spouse/Partner and Children sections)*

Patient Information

YOUR NAME

FIRST NAME *

LAST NAME *

MIDDLE NAME

PREFERRED NAME — *WHAT SHOULD WE CALL YOU?*

ABOUT YOU

DATE OF BIRTH (MM / DD / YYYY) *

SEX *

☐ Male ☐ Female

WHERE YOU LIVE

STREET ADDRESS *

APT, SUITE, ETC.

CITY *

STATE *

ZIP *

HOW TO REACH YOU

PHONE — PRIMARY *

PHONE — SECONDARY

EMAIL *

PREFERRED COMMUNICATION * — *CHECK ALL THAT APPLY*

☐ Email ☐ Text ☐ Phone ☐ Portal

A FEW MORE DETAILS

PREFERRED PHARMACY * — *NAME AND TOWN*

EMPLOYER

HOW DID YOU HEAR ABOUT US? *

☐ Word of mouth ☐ Website ☐ Provider referral ☐ Social media ☐ Other

IF WORD OF MOUTH — WHO REFERRED YOU?

Emergency Contact

Someone we can reach in an emergency. This applies to everyone on this enrollment.

CONTACT NAME * PHONE *

RELATIONSHIP *

☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Friend ☐ Other

Spouse or Partner — *family enrollment only*

Address and emergency contact are shared with the patient above unless noted.

FIRST NAME * LAST NAME *

MIDDLE NAME PREFERRED NAME

DATE OF BIRTH * SEX *

☐ Male ☐ Female

PHONE — *OR* ☐ SAME AS PATIENT EMAIL — *OR* ☐ SAME AS PATIENT

PREFERRED PHARMACY — *OR* ☐ SAME AS PATIENT EMPLOYER

Children & Dependents — *family enrollment only*

Enrolling more than three dependents? Complete these three, then use the **Additional Dependents** continuation sheet (last page) — print one copy per 16 additional dependents.

DEPENDENT 1

FIRST NAME * LAST NAME * PREFERRED NAME

DATE OF BIRTH * SEX * PHONE / EMAIL — *IF ANY*

☐ Male ☐ Female

☐ Same pharmacy as parent ☐ Same address as responsible party ☐ Same emergency contact as responsible party

IF DIFFERENT — PHARMACY / ADDRESS / EMERGENCY CONTACT

DEPENDENT 2

FIRST NAME * | LAST NAME * | PREFERRED NAME

DATE OF BIRTH * | SEX * | PHONE / EMAIL — *IF ANY*

☐ Male ☐ Female

☐ Same pharmacy as parent ☐ Same address as responsible party ☐ Same emergency contact as responsible party

IF DIFFERENT — PHARMACY / ADDRESS / EMERGENCY CONTACT

DEPENDENT 3

FIRST NAME * | LAST NAME * | PREFERRED NAME

DATE OF BIRTH * | SEX * | PHONE / EMAIL — *IF ANY*

☐ Male ☐ Female

☐ Same pharmacy as parent ☐ Same address as responsible party ☐ Same emergency contact as responsible party

IF DIFFERENT — PHARMACY / ADDRESS / EMERGENCY CONTACT

Membership

BILLING FREQUENCY

☐ Monthly ☐ Semi-annual *(family)* ☐ Annual *(family)*

Your rate will be confirmed by our staff from the practice rate schedule in effect on your start date.

Signature

I certify that the information above is complete and accurate to the best of my knowledge, and I will notify the practice of any changes. My **Membership Agreement**, **Consent for Treatment**, and acknowledgment of the **Notice of Privacy Practices** are separate documents that I will review and sign.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY * | DATE *

PRINT NAME * | RELATIONSHIP TO PATIENT

OFFICE USE ONLY

ENTERED BY | DATE ENTERED | ASSIGNED PHYSICIAN | RATE APPLIED

Enter via Onboarding → **Paper form** (app.ocfm.com/onboarding/staff). Insurance photos and e-signature are intentionally skipped on this flow — this signed sheet is the record. File it.

Additional Dependents

Continuation sheet for the New Patient Registration Form. Print additional copies as needed.

RESPONSIBLE PARTY — PRINT NAME *

SHEET _____ OF _____

Leave the three "same as" columns ticked where the dependent shares the responsible party's pharmacy, address, and emergency contact. Note any exceptions below, by line number.

	FIRST NAME *	LAST NAME *	PREFERRED NAME	DATE OF BIRTH *	SEX * M / F	PHONE / EMAIL *IF ANY*	SAME PHARMACY	SAME ADDRESS	SAME EMERG. CONTACT
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

EXCEPTIONS — NOTE THE LINE NUMBER

SIGNATURE OF RESPONSIBLE PARTY *

DATE *