Cary Rheumatology & Arthritis Associates PA
1720 NW Maynard Rd, Cary NC 27513
919-344-0180 (P), 919-851-1900 (F)

New Patient Registration

Patient Name _____ Gender ☐Male ☐Female D.O.B_____

Address_____ City_____ Zip Code_____

Phone (H)_____ (W)_____ (C)_____

*Can we leave a voicemail on your phone? ☐Yes ☐No Which number? ☐Home ☐ Work ☐ Cell
*Preferred Time to call you or leave VM: ☐ Morning ☐ Afternoon ☐ Evening
Can we text your cellphone for a visit reminder/account balance reminder? ☐Yes ☐No

* Email _____ (**ONLY** for reminders and patient portals)

Per HIPAA guidelines, our office will not communicate via personal email with any patient.

*Emergency Contact _____ Relation_____ Phone #_____

***Do you give permission to discuss or send your medical history to this person? ☐Yes ☐No**

Referring Physician Information

Name _____Practice Name _____

Phone #_____ Fax #_____

Primary Care Provider

Name _____Practice Name _____

Phone #_____ Fax #_____

**Insurance Information **

Primary Medical Insurance _____ Member ID_____

*Primary Cardholder _____ Relation _____ DOB _____

Secondary Medical Insurance _____ Member ID_____

Primary Cardholder _____ Relation _____ DOB _____

Pharmacy Information

Name _____Address _____

Phone #_____ Fax #_____

Bring this completed form on the appointment day with an insurance card and photo ID.

I certify that the above information is true and accurate.

Print Name _____Signature _____Date_____