TRIANGLE
WELLNESS & RECOVERY

NEW PATIENT REGISTRATION

Todays Date _____

Personal Information

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____

Date of Birth _____ Age _____

Address _____

Mailing Address (if different from above) _____

Gender O Female O Male O Transgender O Non-Binary O Other _____

Pronouns O She/Her O He/His O They/Them O Ze/Hir O Other _____

Phone Numbers and Email

Cell _____

Home _____

Work _____

Email _____

May We:

Yes / No Leave Detailed Voicemails

Yes / No Leave Voicemails with Call Back Number Only

Yes / No Send Text Messages

Yes / No Send Emails

Would you like to receive emails from our mailing list? Yes / No

Emergency Contact (Local)

Name _____ Relationship _____

Phone Number _____

1000 Darrington Drive, Suite 204, Cary, North Carolina 27513 | (P) 919.338.5620 | (F) 919.336.4519 | info@twrnc.com

Primary Insurance (See Financial Agreement)

Plan Provider _____

Policy / ID Number_____

Group Number _____

Primary Subscriber Name _____

Primary Subscriber DOB _____

Primary Subscriber Zip Code _____

Primary Subscriber Employer _____

Phone Number for Providers _____

Primary Care Physician(s)

Name / Group _____

Address / Location _____

Phone Number _____

(Medical Visits Only) Preferred Pharmacy

Name _____

Address / Location _____

Phone Number _____

How did you hear about us?

O Primary Care O Family / Friend O Business/Organization O Website / Search

Details: _____

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