New Patient Appointment Request Form

PRINT

Name: _____ Date of Birth: _____

Address:_____

Home Phone # _____ Cell # _____ Work #

Primary Insurance: Member ID#_____ Group #_____

Secondary Insurance: _____ Member ID#_____ Group #_____

Please list all current medications and dosage:

1)	4)	7)
2)	5)	8)
3)	6)	9)

Please list all on-going medical conditions (hypertension, diabetes, etc.)

1)	4)	7)
2)	5)	8)
3)	6)	9)

Last Primary Care Physician: _____ Phone:_____

Address: _____ Fax:_____

Reason for leaving your last Primary Care Physician? (◯) Relocating (◯) Second opinion (◯) Other
Explain:_____

_____

Please list any specialists that you see on a regular basis (NAME, ADDRESS & SPECIALTY)

_____

_____

_____

If your child is establishing are you willing to vaccinate according to the CDC Recommendations for immunizations?
_____ YES _____ NO

Would you prefer an appointment with a specific provider or first available? _____

+ Upon scheduling you agree to pay a deposit of $50 as a measure of good faith to keep the scheduled appointment. This will be applied to your copay or deductible at your first visit.

How did you hear about our practice? Friend or relative _____ (list their name)
Website _____ Phonebook _____ Another Physician Practice _____

By signing you acknowledge that all medical conditions and medications are complete and accurate. Any falsifying of this information may result in immediate dismissal.

_____ _____
Signature Date