New Patient Appointment Request Form

Name: ______________________________ Date of Birth: ______________

Address: ____

Home Phone # ______________ Cell # ________________ Work # __________

Primary Insurance: ______________________________

Secondary Insurance: ______________________________

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

0005