NEW PATIENT INFORMATION SHEET DATE: _____

DOCTOR REQUESTED: _____ SS# _____

PATIENT NAME: _____ **DOB:** _____

MAILING ADDRESS: _____

PHONE # _____ **ALTERNATE #** _____

EMAIL: _____

DO YOU HAVE A PRIMARY CARE PHYSICIAN? ☐ **YES** ☐ **NO**

If YES, who IS your primary care physician? _____
If NO, who WAS your primary care physician? _____

HAVE YOU SEEN YOUR PCP IN THE PAST 2 YEARS? ☐ **YES** ☐ **NO**

If YES, how often do you go to see the physician? _____

REASON CHANGING PHYSICIANS

Have you ever been discharged from another physicians practice? ☐ **YES** ☐ **NO**
Have you changed Physicians frequently? ☐ **YES** ☐ **NO**

HOW MANY TIMES HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST YEAR? _____

ARE YOU SEEING ANY SPECIALISTS? ☐ **YES** ☐ **NO If YES, who?** _____

INSURANCE NAME: _____ **INS. PHONE#** _____

INSURANCE POLICY# _____ **GROUP#** _____

MEDICATIONS: _____

_____

CURRENT MEDICAL PROBLEMS: _____

_____

ALLERGIES: _____

REMARKS: _____

REC'VD BY: _____ **APPOINTMENT DATE/TIME:** _____

_____

OFFICE USE ONLY

Insurance Verification
Spoke to: _____ **Copay:** _____ **Pays:** _____
Comments _____

_____

_____

Your acceptance as a patient will be determined by accurate / complete information on this form. Incorrect information my result in being discharged as a patient