Pending New Patient Questionnaire

Disclaimer: Due to the size and capacity of the practice, filling out this form and/or transferring your medical records DOES NOT guarantee acceptance as a new patient.

What do you need to see the Provider for? (Please check all that apply)

○ Physical ○ Sick Visit ○ Medication Refill ○ Only to Establish Primary Care

○ New Baby Consult (Baby Due Date :________________________________)

○ Other (please describe): ____

What medication are you currently taking? We require this medication list upon your first appointment (NO EXCEPTIONS). Please attach medication list.

____

____

Current medical problems/Diagnosis:

____

____

Previous Treating Physician: ____

Are your medical records being transferred? (Y / N)

If no, please explain: ____

Reasons for transferring care: ____

If new baby consult, does the child have any disability that would require special needs?

If so, please explain: ____

Who is your OB Physician? ____

Immunization Concerns: As a parent, are you opposed to your child receiving the CDC recommended childhood immunizations? (Y / N)

We require Shot Cards or Immunization Records upon First Appointment (NO EXCEPTIONS)

Physician Assistant (PA): This practice does employ a PA. As a patient are you opposed to being seen or treated by the PA for routine preventative care, follow-up exams, and/or sick visits? (Y / N)

Personal Contact Information: Patient Name: ____

Telephone #: _________________________________ Secondary Phone #: ______________________

Address: ____

Social Security #: (________-______-________) Date of Birth: (______/______/__________)

Insurance Information: **(all fields required)**

Primary Insurance Name: ________________________________ Policy #: ________________________

Group #: _____________________________________ Insurance Phone #: (______-______-________)

Insured's Name: ________________________________ Relationship to Patient: ___________________

Insured's Date of Birth: (______/______/________) Insured's Social Security #: (______-____-______)

Do you have a secondary Insurance? (Y / N/) If so, please list carrier: ___________________________