Prospective New Patient Information Sheet

DATE: _____ RECEIVED BY: _____

NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: HOME: _____ CITY OF RESIDENCE: _____

CELL: _____ WORK: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

CURRENT PHYSICIAN: _____

CURRENT MEDICATIONS: _____

_____

ILLNESSES : _____

PHYSICIAN REQUESTED 1ST CHOICE: _____ 2ND CHOICE: _____

Any Family Members current patients of this practice? _____

Family Member Name: _____ **PHYSICIAN:** _____

REFERRED BY: _____ PHYSICIAN / EMPLOYEE

Office Use Only:

Contacted by: _____ Date: _____

Please complete this form. We will also need a current copy of your insurance card (s) and a photo ID to process your new patient request.

Please return this request to our front office staff. We will contact you either by phone or mail.

If you are in urgent need or if this is an emergency, please report to the local Urgent Care Center or Emergency Department.

Your completion of this form does not guarantee you will be accepted as a new patient. A review of the information you have provided will be completed. Your acceptance is determined by the number of new patient requests we currently have to review, insurance restrictions, and provider availability.

Hazelwood Family Medicine, PLLC