Application must be dropped off in office

THE FAMILY MEDICINE CENTER

Date: _____ **NEW PATIENT APPLICATION** ***Please print legibly***

Patient. Name: _____DOB_____ /_____ /_____ Gender: M____F____

Mailing Address: _____City: _____ Zip: _____

Phone: (home)_____ (bus) _____(cell)_____

Email: _____

Primary Insurance: _____

Subscriber's Name _____ DOB_____ Gender: M____ F_____

ID#_____Group # _____Out-of-state insurance, obtain toll free #: _____

Secondary Ins: _____

Subscriber's Name _____ DOB_____ Gender: M____ F_____

ID#_____Group # _____Out-of-state insurance, obtain toll free #: _____

Why do you want to be a patient here?_____

Who is your current Doctor or most recent Doctor? _____Last Visit:_____

Do you need for an urgent appointment? □ No □ Yes Please specify:_____

Please list all medications you are currently taking (include supplements and over the counter):_____

_____

_____

Do you take any long-term medications for pain or anxiety?" □ No □ Yes Please specify:_____

_____

Do you have any Motor Vehicle Accident injuries? □ No □ Yes If Yes, Are your injuries still being treated? □ No □ Yes
Do you have any Industrial Work Accidents? □ No □ Yes If Yes, Are your injuries still being treated? □ No □ Yes

***Please note: our office does not treat work related injuries or motor vehicle accident injuries.**

Minor Children only: Is your child physically or mentally challenged?: □ No □ Yes
Are your child's vaccinations up-to-date?: □ No □ Yes

Who referred you to our office?_____

Person completing this application if not patient listed above: _____Relationship:_____

Phone number: _____

PLEASE BRING YOUR ID AND INSURANCE CARD(S) AT DROP OFF

Completing this application does not establish you as a patient of The Family Medicine Center, nor does it begin a patient-provider relationship. This is only a request to become a patient of The Family Medicine Center, and acceptance is at the discretion of the providers.

*****This request is only valid for 90-days from the date of submission*****

Date Received: _____ ***For office use only***
Billing: Insurance Accepted*:* YES NO Date: _____

Accept Pt: **Y N** Assigned Care Team: **Dolan Kalua Belcher Louchheim**
Notified of acceptance & instructed to pick-up reg pkt: _____/_____
Date packet picked-up: _____/_____ Packet Received: _____/_____

Appt date:_____with: _____

HMO Inform change PCP: _____

(DATE/sign all lines)

WEB-VERSION