NEW PATIENT REQUEST FORM

DOCTOR_____COMMENTS_____

DATE_____ _____

NAME_____ _____

ADDRESS_____ _____

_____ _____

PHONE: h _____w _____ext_____cell_____

DOB_____ INSURANCE_____

OTHER FAMILY MEMBERS REQUESTING TO BE ACCEPTED W/DOB: _____

_____

_____

ANY ONGOING MEDICAL PROBLEMS_____

_____

MEDICATION TAKEN ON A REGULAR BASIS_____

_____

CURRENT DOCTOR_____

WHY ARE YOU LEAVING_____

HOW DID YOU HEAR ABOUT OUR PRACTICE_____

OFFICE COORDINATOR'S INITIALS_____

COMPUTER CHECKED_____PT IN EMR_____PT NOT IN EMR_____

DOCTOR APPROVAL_____DATE PATIENT NOTIFIED/ENTERED INTO EMR_____OK TO SCAN?_____