MSFM NEW PATIENT APPLICATION

Please provide the following information so that we may help you find the most appropriate setting to obtain health care.

Date:_____ Name:_____ Birth Date_____

Phone: hm:_____ cell:_____ Employer:_____

New in town? ○Yes ○No Mailing Address:_____

Referral source ☐family ☐friend ☐ad ☐phone book ☐other(list)_____

Why looking for a(new) doctor_____

Payment method: ☐Cash ☐Insurance if Ins. What type_____
Ins ID:_____Group #:_____Primary Insured:_____

Main reason you want to be seen:_____

Medical problems/history:_____

_____

Who is the current medical provider/clinic_____ date last seen there_____

Why were you seen_____

Will you sign a medical record release ☐YES ☐NO if NO, why not_____

Hospitalizations in the last two years/where_____

LIST ALL MEDICATIONS: _____

_____

Any other family members needing to establish: (list with ages)_____

_____

Anything we should know, such as latex allergies, disabilities, wheelchair, special requirements:

_____

ALL NEW PATIENTS MUST BRING PHOTO ID & CURRENT INSURANCE CARD.

MSFM NO LONGER ACCEPTS MEDICARE PAYMENT. MEDICARE PATIENTS MAY BE SEEN UNDER PRIVATE CONTRACT WITH MSFM.