TEXAS FAMILY WELLNESS CLINIC
Ron Guevara, D.O.

NEW PATIENT APPLICATION

Patient Name: _____ Date of Birth:____/____/____ Date of App: ____/____/____
Phone Number: _____ Email: _____
What current Chronic Issues do you have? *(Diabetes, High Blood Pressure, High Cholesterol, Anxiety/Depression, etc.)*

What current prescription medications do you take?

What current vitamins & supplements do you take?

Who was your previous Primary Care Doctor?

Which Provider/Doctor at our clinic are you requesting to see?

What concerns or issues do you need to discuss with the Doctor on your first visit with us?

What past surgeries have you had in your lifetime?

Why do you want to be a patient at Texas Family Wellness Clinic?

What are your short-term & long-term health & wellness goals?

What are your expectations as a patient at Texas Family Wellness Clinic?

How did you hear about us?

Circle Yes or No for the following questions.

Yes No Are you open-minded to alternative treatment options?

Yes No Would you be willing to see the Registered Dietitian if the Doctor recommends it?

Yes No Would you be willing to take vitamins and/or supplements if the Doctor recommends it?

Check the boxes below to acknowledge the statements have been read and understood.

- ☐ I understand that if I am late to my appointment, do not show up, and/or cancel within 24 hours of my appointment time, I may not be seen as a new patient at this clinic and may not be rescheduled.
- ☐ I understand that this application submission is not a guarantee that I will be accepted as a patient.
- ☐ I understand that Texas Family Wellness Clinic does not prescribe Narcotic Medications such as, but not limited to Hydrocodone, Codeine, Oxycodone, Opium, Xanax, Alprazolam , Clonazepam, Valium.
- ☐ I understand that Texas Family Wellness Clinic does not prescribe weight loss medications.
- ☐ I have sent a text with a picture of my photo ID and the front and back of my insurance card to 361-600-7018 to verify my insurance benefits or stopped by the clinic in-person to have a photocopy made prior to the submission of this application. (Selfpay patients must provide their Photo ID only)

By signing below, I hereby acknowledge that what I have provided on and in connection with this form is true and correct to the best of my knowledge. I also understand that any false statements or deliberate omissions on this form may subject me to be terminated as a patient of Texas Family Wellness Clinic.

X_____ Date Signed: ____/____/_____

Patient's Signature

Please email the completed application to aguevara@texasfamilywellnessclinic.com, fax to 800-990-5305 or drop off in-person at 15406 Northwest Blvd, Ste. B; Robstown, TX 78380.

FOR INTERNAL USE ONLY

Received: ___/___/____ By: _____

__Approved By: Dr._____

__Denied By Dr._____

TX DPMP Website Search Date: ___/___/____ By: _____ See Attached / No Record