

NEW PATIENT INQUIRY & INTAKE FORM

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Welcome to Sussex NP Primary Care!

We appreciate your interest in becoming a patient at our practice. Please complete this form as thoroughly as possible so our team can better understand your healthcare needs.

Once completed please email, fax, or mail to office for review

SECTION 1 – PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Sex Assigned at Birth: _____

Marital Status: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____

Secondary Phone: _____

Email: _____

Preferred Contact Method:

☐ Phone ☐ Text ☐ Email

Preferred Language: _____

Do you require an interpreter? ☐ Yes ☐ No

Emergency Contact: _____

Relationship: _____ Phone: _____

SECTION 2 – INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Plan Name: _____

Policyholder Name: _____

Policyholder DOB: _____

Member ID: _____

Group Number: _____

Relationship to Policyholder: _____

Secondary Insurance (if applicable)

Insurance Company: _____

Policyholder Name: _____

Member ID: _____

Group Number: _____

☐ Copy of insurance card attached (front and back)

SECTION 3 – MEDICAL HISTORY

Previous Primary Care Provider: _____

Previous Practice: _____

Date of Last Physical: _____

Do you have any chronic medical conditions?

☐ Yes ☐ No

If yes, please list:

Have you had any recent hospitalizations or emergency room visits?

☐ Yes ☐ No

If yes, please explain:

Are you currently seeing any specialists?

☐ Yes ☐ No

If yes, please list:

SECTION 4 – CURRENT MEDICATIONS

Please list all prescription medications, over-the-counter medications, vitamins, and supplements.

Medication Dosage Frequency Reason

☐ Medication list attached

SECTION 5 – ALLERGIES

Do you have any known allergies?

☐ No Known Allergies (NKA)
☐ Medication allergies
☐ Food allergies
☐ Latex allergies
☐ Environmental allergies
☐ Other: _____

Please list allergies and reactions:

Allergy	Reaction

SECTION 6 – SURGICAL HISTORY

Please list all previous surgeries and procedures.

Surgery/Procedure	Approximate Date	Facility

SECTION 7 – FAMILY MEDICAL HISTORY

Please indicate any significant family medical history.

☐ Heart Disease
☐ High Blood Pressure
☐ Diabetes
☐ Cancer
☐ Stroke
☐ Kidney Disease
☐ Thyroid Disease
☐ Mental Health Conditions
☐ Other: _____

Family member and additional details:

SECTION 8 – SOCIAL HISTORY

Tobacco Use

☐ Never smoked
☐ Former smoker
☐ Current smoker
☐ Vape/e-cigarette use
☐ Other tobacco use

If applicable, how much and for how long?

Alcohol Use

☐ None
☐ Occasionally
☐ Weekly
☐ Daily

Other Substance Use

☐ None
☐ Yes
☐ Prefer not to answer

If applicable, please explain:

Lifestyle

Do you exercise regularly? ☐ Yes ☐ No

Type/frequency: _____

How would you describe your diet?

☐ Regular/Well-balanced
☐ Low carbohydrate

☐ Vegetarian
☐ Other: _____

SECTION 9 – PREVENTIVE HEALTH HISTORY

Please provide approximate dates of your most recent screenings, if applicable.

Last Mammogram: _____

Last Pap Smear: _____

Last Colonoscopy: _____

Last Dental Exam: _____

Last Eye Exam: _____

Last Immunizations: _____

Other screenings or preventive care:

SECTION 10 – COMMUNICATION PREFERENCES

How would you prefer our office to contact you?

☐ Phone call
☐ Text message
☐ Email

Best time to contact you:

☐ Morning
☐ Afternoon
☐ Evening

Do you prefer communication in another language?

☐ Yes ☐ No

If yes, which language? _____

Is there anything we should know to help communicate with you effectively?

SECTION 11 – NEW PATIENT INQUIRY

What is the primary reason you are seeking a new primary care provider?

☐ Establishing primary care
☐ Annual physical
☐ Chronic disease management
☐ Medication management
☐ Preventive care
☐ Recent relocation
☐ Other: _____

What are you looking for in a primary care provider?

How did you hear about Sussex NP Primary Care?

☐ Family/Friend
☐ Online Search
☐ Insurance Directory
☐ Provider Referral
☐ Other: _____

Preferred Pharmacy:

Pharmacy Name: _____

Address/Location: _____

Phone: _____

SECTION 12 – ADDITIONAL INFORMATION

Please share any additional information or healthcare concerns you would like our team to know.

SECTION 13 – PATIENT ACKNOWLEDGMENT

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

I understand that completing this inquiry form does not establish a provider-patient relationship or guarantee acceptance into the practice.

Patient/Prospective Patient Name: _____

Patient Signature: _____

Date: _____

THANK YOU FOR YOUR INTEREST IN SUSSEX NP PRIMARY CARE!

Healthcare That Feels Like Home

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Office Use Only

Date Received: _____

Insurance Verified: ☐ Yes ☐ No

Records Requested: ☐ Yes ☐ No

New Patient Appointment: _____

Staff Initials: _____