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New Patient Application

Today's Date: ______________________________ Gender: ☐ Male ☐ Female

Name: ____ DOB: ________________
First Middle Last

Address: ____
Mailing Address City State Zip

Phone: (______)________-___________ (_______)________-___________ (_______)_________-___________
Home Work Cell

Email Address: ____

Current Physician: ____

Reason for Changing Physician: ____

Specialist you are currently receiving services from: ____

Who referred you to our facility: ____

What do you need to be treated for: ____

Do you have a history of: ☐ Anxiety ☐ Diabetes ☐ Cancer ☐ High BP ☐ Depression ☐ Chronic Pain* ☐ ADD

Current Medications: ____

Do you take: ☐ Xanax (Alprazolam) ☐ Vicodin (Hydrocodone) ☐ Soma (Carisoprodol)
☐ Ativan (Lorazepam) ☐ Testosterone* ☐ Adderall/Vyvanse/Concerta/Ritalin

Name of Insurance: ____ Ins Phone #: __________________________

Subscriber/Member ID#: ____________________________________ Group #: _____________________________

✱This office does NOT prescribe chronic pain medications and will NOT treat Testosterone in males younger than 35!

Office Use Only

Appointment Date & Time: ________________________________ SS#: ____________________________________

Failure to disclose **ALL** medications will result in termination of any further treatment.

New patients establishing with our clinic that have pre-existing chronic painful conditions are hereby notified that we **DO NOT** provide chronic pain treatment and are advised to seek treatment elsewhere.

Payment is due in full at the time of service. Cash/Credit ONLY. You will be required to show your insurance card prior to each appointment. If we are unable to verify your insurance at the time of visit, you will be responsible for the full payment of the visit at the time of service.

Patient Name: ______________________________ DOB:______________

Signature:____