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New Patient Application

Today's Date: _____

Name: _____ DOB: _____
First Middle Last

Address: _____ Sex: ☐ Male ☐ Female
City State Zip

Phone: ( )_____-_____ ( )_____-_____ ( )_____-_____
Home Work Cell

Current Physician: _____ Specialty: _____

Reason for Changing Physician: _____

Specialists you are currently receiving services from: _____

Who referred you to our facility? _____

Current Medications: _____

_____

What do you need to be treated for? _____

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

Do you take ☐ Xanax ☐ Alprazolam ☐ Vicodin (Hydrocodone)
☐ Soma ☐ Carisoprodol (Ativan) ☐ Lorazepam

Name of Insurance: _____

Subscriber/Member # _____ Group # _____

Insurance Phone Number: _____

Office Use Only

Appointment Date: _____ Appointment Time: _____

Physician Signature: _____