306 Isabella St
Waycross, GA 31501
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(F) 912- 338-8931
Warexpress@outlook.com

NEW PATIENT APPLICATION

NAME: _____DOB: _____

GENDER: _____ ADDRESS: _____

CITY:_____STATE/ZIP:_____PHONE#_____

INSURANCE: PRIMARY:_____SECONDARY:_____

PREFERRED PROVIDER (CIRCLE ONE)

Ricky Tatum PA-C / Deena Boyd, APRN / Christy Strickland, APRN / ANY PROVIDER

REASON FOR VISIT:

_____

PAST MEDICAL HISTORY/PROCEDURES:

_____

_____

_____

_____

CURRENT MEDICATIONS: Please list all current medication. -ATTACH A LIST IF NEEDED

_____

_____

_____

SIGNATURE (PATIENT OR GUARANTOR): _____

DATE: _____

SEND A COPY OF YOUR INSURANCE CARD WITH APPLICATION *Please be advised that we do not prescribe chronic pain medication at this practice. If you no call/ no show to your scheduled visit there will be a $50 fee which is non-negotiable.

OFFICE USE:

APRROVED: YES – appointment date and time _____ OR NO

RECEIVED BY: _____ DATE: _____