Dayspring Family Medicine New Patient Screening Form

FULL NAME: _____

ADDRESS: _____ CITY/STATE/ZIP _____

CELL/HOME PHONE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____ SEX: _____

EMPLOYER: _____ INSURANCE: _____

RESPONSIBLE PERSON: _____

RESPONSIBLE PERSON DATE OF BIRTH: _____ PHONE NUMBER: _____

RESPONSIBLE PARTY ADDRESS: _____

SPOUSE'S NAME: _____ PHONE: _____

MEDICATIONS CURRENTLY TAKING: _____

_____

_____

PAST MEDICAL HISTORY: _____

_____

LIST OF DOCTORS SEEING NOW: _____

_____

ANY IMMEDIATE FAMILY MEMBERS PATIENTS HERE? ____ IF SO, WHO AND WHAT RELATIONSHIP: ____

_____

WHAT PROVIDER DO YOU PREFER TO SEE: _____

I understand that Dayspring Family Medicine is a private practice. It is at the discretion of the providers in the practice to determine which patients are accepted.

I understand that this form is an application. Completing it and turning it in does not guarantee acceptance into our practice and subsequent medical care.

Signature and Date: _____

FOR STAFF COMPLETION ONLY:

PATIENT HERE BEFORE: _____ IF SO, LAST DATE SEEN: _____ DISCHARGED: _____

TRANSFERED RECORDS: _____ COLLECTIONS: _____

EMPLOYEE NAME AND DATE: _____