

Family Practice of Cadillac

New Patient Request Form

Please Print Clearly

*If form is not complete this application will not be reviewed by any physicians within this office, please put N/A if the question does NOT apply.

Date:
Name:
Date of Birth:
Phone Number:
Address:
Insurance: Primary: _____ Secondary: _____
Current Medical History: (ex: diabetes, chronic pain, depression / anxiety)
Do you take ANY medications? Yes No If Yes, please List ALL current medications:
Please list any other forms of medication you currently use? (ex: Medical Marijuana)
Are you currently OUT of medications?
How soon are you in need of an appointment?
Were you referred to us; if so by who?
Do you have family that comes here? Please list First, Last Names, and Relationships
Do you have family members that want to become our patients as well? Please List Name and Age.
Which doctor are you interested in seeing?
Previous Doctor:
Reason for switching doctors?
Please list any other physician you see. (ex: OB/GYN, Cardiologist)
Comments:

**Please note that we will contact you if the doctor accepts you as a patient. This process could take up to 2 - 3 weeks. If you are in need of an appointment before that please indicate how soon you need to be seen in the appropriate field above.

Office Use Only

Date Received: _____ Approved: Yes No Doctor Signature: _____

Date Pt Notified: _____

Appt Date: _____

Employee Intials: _____

Last Updated 2/5/2014