Office Use:_____
eCW Y N
Medicaid Y N
Emp Initials_____

Family Practice of Cadillac

New Patient Request Form

Please Print Clearly

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

Name:	Date:	
Previous Name(s):		
Date of Birth:		
Home Phone Number:	Cell Phone Number:	
Address:	City:	State:
Insurance: Primary:	Secondary:	
Current Medical History: (ex: diabetes, heart condition, chronic pain, depression / anxiety)		
Do you take **ANY** prescription medications? Yes No	If Yes, please List **ALL** current medications:	
Please list any other forms of medication you currently use? (ex: vitamins, supplements, 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 come here? Please list first, last name, and relationship.		
Do you have family members that want to become our patients as well? Please list name(s) 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:		

After this request is reviewed, you will be contacted as to whether it is accepted or declined. Please allow 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: 06/10/2022