New Patient Request Form

Please submit this form either by fax: 316-440-6601 or email: jsaleem@newmed.pro

New Medical Health Care strives to provide quality care to all of our patients. Please allow 24-48 hours to process your request.

Date: _____

Full Name:_____Date of Birth:_____
Address:_____ City_____State _____
Zip Code _____ Phone Number: _____

email address required:_____

If request is for a minor, please list Responsible Party's Name:_____

Are you insured or will you be self pay? _____
If insured, please fill in the following information:

Primary Insurance Company_____
Claim Address _____
Subscriber ID Number _____Group Number _____
Subscriber's Name _____Date of Birth _____

Secondary Insurance Company_____
Claim Address _____
Subscriber ID Number _____Group Number _____
Subscriber's Name _____Date of Birth _____

Reason for Appointment/Current Health Concerns: _____
_____

Current Medication List: _____
_____
_____

Chronic Health Conditions, i.e. Diabetes, Hypertension, COPD or other: _____
_____
_____
_____

Requested primary care provider:_____

Comments/Questions: _____
_____
_____

***** New Medical Health Care is a primary care clinic. We cannot effectively coordinate care if you receive treatment from another primary care provider outside of our clinic. *******