New Patient Request Form

Please submit this form either by fax: 316-440-6601 or email: dpacker@newmed.pro
(a scanned document only – no pictures)

***** If this form is not filled out completely, your request may not be processed *****

Today's Date:			
Full Name		**Date of Birth**	
Complete Address			
Home Phone		Cell Phone	
Email address (required):			

Responsible Party's Name		Relationship	

Self-Pay: ☐ YES ☐ NO			
Primary Insurance Co.			
Claim Address			
ID Number		Group Number	
Subscriber's Name		Date of Birth	
Secondary Insurance Co.			
Claim Address			
ID Number		Group Number	
Subscriber's Name		Date of Birth	

Reason for Appointment/ Current Health Concerns:	
Current Medications *(Be sure to bring your medication list to your first appointment)*	
Chronic Health Conditions: *(i.e. Diabetes, Hypertension, COPD)*	

Requested Primary Care Provider:	

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.

Comments/Questions:	

Office use only	

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