New Patient Request Form

Please submit this form, **along with a front and back copy of your insurance card(s)**, by email to dpacker@newmed.pro

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

Today's Date:			
Full Name		**Date of Birth**	
Street Address			
City, State, Zip Code			
Home Phone		Cell Phone	
Email address (required):			
Responsible Party's Name, if patient is a minor		*Relationship*	

Self-Pay: ☐ **YES** ☐ **NO, I have insurance.** *Complete the information below and include a front and back copy of your insurance card(s)*			
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	

Who are you requesting to see at our clinic?	
Reason for Appointment/ Current Health Concerns:	

New Medical Health Care is a primary care clinic. We cannot effectively coordinate care if you receive treatment from another PCP outside of our clinic. All requests are subject for review of the Kansas Prescription Drug Monitoring Program (K-TRACS).

Comments/Questions:	

Please allow 24-48 hours to process your request.

Office use only		