**New Patient Request Form**

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date: | Initials: | |  | | | |  | | | |  |
| **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* | | | |  | | | |

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| --- | --- | --- | --- | --- |
| **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 |  |

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| **Who are you requesting to see at our clinic?** | |  |
| **Current Health Concerns:**  **Reason for NP Appt:**  **Chronic Conditions:**  **Current Medications:** |  | |
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| *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).* | | |

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| *Office use only* |  |  |
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