NEW PATIENT APPLICATION

DATE: _____ **NAME**: _____**MID INITIAL**: ____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: _____ **WORK/CELL PHONE:** _____

OK to Leave a Voice Message: Yes or No **SEX:** Male or Female

DOB: _____ **Email Address:** _____

PREFERRED DOCTOR: _____ **OK to Check with others?** Yes or No

INSURANCE: _____

REFERRAL SOURCE: _____

Previous Doctor: (If you are switching doctors, list the reason for wanting to switch from your current provider.) _____

PATIENT HEALTH HISTORY: (If you need to be seen ASAP, please give reason you're needing seen.)

_____

_____

_____

Current Medications: _____

_____

_____

_____

Surgeries within Last 2 yrs: _____

_____

_____

*I understand that filling out this form is not a guarantee of acceptance. I agree to physically drop off, mail or fax (Fax #: (402) 423-0739) this form only to the office for processing. Once my form has been received, I understand I may receive a call with additional questions before it is taken to a provider. Please allow 48 hours for processing. If you have any additional questions, please call the office as we would be happy to assist you.