Singletrack Health New Patient Request Form

Date form completed: _____

(Please fill out a separate form for each member of your household)

Name: _____

Date of Birth: _____

Phone number: Home_____ Cell _____

Address: _____

Insurance: _____

List any medications you are currently taking:

_____

_____

_____

List any Chronic Conditions (ex: diabetes/hypertension/etc.):

_____

_____

_____

Who are your current physicians? _____

What is the reason you are leaving your current physician's office?

_____

_____

_____

Previous Physicians: _____

Were you referred by one of our current patients? If so, who?

_____

Our office follows the Center for Disease Control's recommended guidelines regarding vaccines. How do you feel about vaccination?

_____

_____

_____

****IF YOU HAVE AN URGENT NEED TO SEE A PHYSICIAN, PLEASE CONTACT YOUR NEAREST EMERGENCY DEPARTMENT OR WALK-IN CENTER. THESE FORMS ARE ASSESSED ONLY ON AN INFREQUENT BASIS WHEN AND IF WE ARE ABLE TO ACCOMMODATE NEW PATIENTS****

Please note that completion of this form is not a guarantee of acceptance into the practice. In the event that there is an opening, our office will contact you.