Previous balances will be paid before reacceptance

ACC patients must go through New Patient Process.

Name: ______________________
DOB: ______________________
Address: ______________________
____
____
Phone: ______________________

New Patient Past Medical History Form

Have you been seen by a doctor anywhere in the last 5 years? Yes No
Do you have a Medicare Advantage plan? Yes No (We only accept traditional Medicare)
Reason for wanting to establish care? (general wellness, problems, etc)

____
____
____

Surgical History (Type, body part, date): ______________________________
____
____

Family History: (Alive, deceased, medical problems)

Father: ______________________________
____
Mother: ______________________________
____
Siblings: ______________________________
____
Other: ______________________________
____

Social History:

Relationship: Married Divorced Single
Living Situation: ______________________________
Children: Yes No If yes, how many and age(s)? ______________
Employment: ______________________________

Medications: ____
____
____

Allergies: ____
____
____

Do you have any relatives that are patients of the practice? Yes No
If yes, whom and relationship: ______________________________

Signature: ______________________ Date: ____________