Lovelace Family Medicine

Previous balances will be paid before reacceptance. ACC patients must go through New Patient Process.

Name:_____ Date of Birth:_____
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: _____