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: _____________