Delta Medical Center New Patient Application

Date: _____

Name: _____

Parents' Names (if under the age of 18): _____

Address: _____

Phone: _____ Date of Birth: _____

Who were you referred by? _____

Have you ever been a patient at our facility? _____

If yes, why did you transfer? _____

Insurance: _____
****You must provide a copy of your insurance card(s) with this application prior to it being reviewed by the provider.**

Medications: _____

_____

_____

Will you need treatment for chronic pain, sleep, anxiety, or ADHD?
_____

Will you need vicodin, percocet, oxycontin, fentanyl patch, valium, ativan, xanax, adderall, ritalin, ambien, or any other controlled substance?
_____
If yes, who is currently prescribing the medication? _____
(At the present time, we are at our capacity to manage patients with controlled substances like the ones listed above. During this period, our physicians are unable to prescribe any controlled substance medications to patients being accepted into our practice. After evaluation, we may refer to pain management or other appropriate provider if necessary.)

Previous Physician: _____

Reason for Leaving Previous Physician: _____
_____

Preferred Provider: _____ or first available

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Physician Decision ***Yes No*** _____