New Patient Request Form

Patient First & Last Name: ____

Address: ____

Guardian Name (if under 18): ____

Daytime Phone: (   ) __________________ Date of Birth: ______/______/______

Primary Insurance Name: ________________________________ ID#: _____________________________

Secondary Insurance Name: ______________________________ ID#:_____________________________

Do you take any **current medications?** If so, please list the medications:

____

____

Have you been prescribed **chronic pain medication** in the past 2 years? If so, please list the medications:

____

____

Medication Allergies:

____

____

Reason for needing seen: (e.g. get established as a patient, illness, out of medications, etc.):

____

* Please return this form completed back to WN Rural Health Clinics
Allow three days for processing

We will call you and let you know if you have been accepted as a new patient to our clinic.

Approved □ **Denied** □