Date: _____

New Patient Request Form

Name: _____ Date of Birth: _____

Gender: M___ F ___ Phone Number: _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____

Preferred Provider: Sotiere Savopoulos, MD Rebecca Crowell, DO Brandi Paugh, CRNP
Patricia Gotsch, MD Juan Ramos, DO

Personal Medical History

Major Illness	**Yes**		**Yes**		**Yes**		**Yes**
Diabetes		Osteoporosis		Clotting Disorder		Arthritis	
High Blood Pressure		Heart Disease		Thyroid Disease		Alcoholism	
GI Reflux Disease		High Cholesterol		Anxiety		Drug Dependence	
Asthma		Hepatitis		Depression			
Fibroids		Liver Problems		Seizures			
Endometriosis		Kidney Infections		Lung Disease			
Osteopenia		Kidney Stones		Tuberculosis			

Medications (Including Suboxone, Marijuana, or Narcotics)

DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

Surgical History

SURGERY	YEAR	SURGERY	YEAR

Family History

Any Family history of breast, ovarian, uterine or colon cancer? If so, who?

_____
_____
_____
_____

Social History:

Smoking: Yes No Packs/day: _____ Years _____ Quit when: _____

Drug Use: Yes No Type: _____ Years _____ Quit when: _____

Alcohol: Yes No Drinks/day: _____ Years _____ Quit when: _____

Hospital Stays: (If yes where and when?)

_____
_____
_____

Specialists:

_____
_____
_____

Primary Reason for Seeking New Primary Care:

_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

_____ _____

Signature of patient, parent, or guardian Date

_____

FOR OFFICE USE ONLY

Approved _____
Denied _____