GOLDEN / primary care

NEW PATIENT FORM

FIRST NAME				
INITIAL				
LAST NAME				
DATE OF BIRTH	month	day	year	
GENDER				
MARITAL STATUS	single	married	divorced	widowed
OCCUPATION				
SSN				
STREET ADDRESS				
CITY / STATE / ZIP	city	state	zip	
PHONE	home	cellphone		
EMAIL				
CURRENT PCP	practice name	provider you normally see		
PRIMARY INSURANCE	insurance carrier	group (if applicable)	member ID	
SECONDARY INSURANCE	Insurance carrier	group (if applicable)	member ID	
PHARMACY	name	location		
EMERGENCY CONTACT	name	telephone number		

CURRENT PRESCRIPTIONS

MEDICATION	DOSE	FREQUENCY
example *Lipitor*	*10mg*	*one tablet daily at bedtime*

ARE YOU ALLERGIC TO ANY MEDICATION? (medication / reaction)

medication	reaction	medication	reaction
medication	reaction	medication	reaction

ANY HISTORY OF THESE? (circle all that apply)

Diabetes	Thyroid Disorders	Stroke	Heart Attack
Hypertension	High Cholesterol	Cancer	Asthma
COPD	Kidney Stones	Depression/Anxiety	Traumatic Brain Injury

Other conditions:

HAVE YOU HAD ANY OF THESE SURGERIES? (circle all that apply)		
Gallbladder	Appendix	Back Surgery
Heart Stents	Open Heart Surgery	Orthopedic Surgery

Other surgeries:

ARE YOU SEEING ANY OF THESE SPECIALISTS? (add specialist name)			
Cardiologist		Nephrologist	
Oncologist		Orthopedic Surgeon	
Psychiatrist / Therapist		Pain Management	

Other specialists:

PREVENTATIVE CARE			
WOMEN		MEN	
LAST PHYSICAL?	date	LAST PHYSICAL	date
LAST COLONOSCOPY?	date	LAST COLONOSCOPY?	date
LAST DEXA SCAN?	date		
LAST MAMMOGRAM?	date		
LAST PAP SMEAR?	date		

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT.

THANK YOU.