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Practice Application Form / Intake Form

The purpose of this form is to help determine if our practice is the right fit for you.

Full Name: ______________________________ Date of Birth: ______________

Address: ______________________________

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Preferred phone number: ______________________

Insurance: ______________________ ID #: ______________________

Secondary insurance: ______________________ ID #: ______________________

Previous primary care physician: ______________________________

How did you hear about us? ______________________________

What medical problems do you have, if any? (diagnoses only please)

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Please list the medications you take, if any, including current prescriptions and over the counter medications and vitamins/supplements:

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Do you take any controlled substances or pain medications such as hydrocodone, Xanax, Ativan? If so, please list:

____

Please complete this form and fax it back to (304) 720-3556 or drop it by the office.

**We will attempt to contact you at your preferred phone number once this form is reviewed. If we are unable to make contact with you after two attempts, this form will be shredded.