Three Rivers Family Medicine, PSC

New Patient Initial Registration

Date ________________

Name ____ DOB ______________________

Address _________________________________City_____________ State __ Zip _____

Home Phone _____________ Work Phone _____________ Cell Phone _____________

Martial Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Male ❑Female

Occupation ____

Employer ____

Current Medical Problems/Reason for visit

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____

Is the reason for visit work related? Yes or No

Is the reason for visit accident related? Yes or No

Is anyone in your family established with TRFM? Yes or No

If so, Who: ____

Have you seen any other medical provider in the last 12 months? Yes or No

If so, Who: ____

Why were you seen? ____

Where? ____

Current Medications ____

Health Insurance ____

Provider Requested: _____________________

Approved or Denied