NUTMEG PRIMARY CARE

Your lifelong care partner

New Patient Intake and Clinical History Form

Name: _____ DOB:_____

Address:_____

Preferred phone number:_____ (Cell)__ (Home)__ (Work)__

Primary Insurance: _____ Secondary Insurance: _____

Current primary care provider: _____

How did you hear about us?_____

Is it difficult for you to leave the home?

No__ (**If so, stop here**)

Yes__ (If so, please click the box(es) explaining why below)

☐ Mobility (use of cane, walker, crutches, wheelchair, bedbound) ☐ Memory deficit

☐ Symptoms with activity (pain, trouble breathing) ☐ Transportation issues

☐ Other (please explain):_____

Please list all chronic medical problems or attach list:

_____

_____

Have you recently been hospitalized? Yes__ No__

If yes, please explain:_____

(Continue on page 2 please)

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New Patient Intake and Clinical History Form (Page 2)

Name: _____ DOB:_____

Please list specialists you have seen in the last 2 years?

1._____ 3._____

2._____ 4._____

Please list medications and dosages (including non-prescribed medications) or attach list.

_____

_____

Have you ever been discharged from a healthcare provider or agency due to noncompliance or behavior?

No__ Yes__ If yes, please explain:_____

By signing below I acknowledge the information provided is correct. Failure to complete this referral form in its entirety or falsifying information may result in referral denial or discharge from the practice.

_____

Patient or representative signature Printed Name/Relationship Date