Reservoir Family Medical Clinic

New Patient Application

Phone (601) 992-6511 ~ Fax (601) 992-5684

Please complete this application to the best of your ability. Remember, all questions are optional and will be kept strictly confidential.

Name

Date of Birth SS# ☐ Female ☐ Male

Address

Phone ( ) Cell ( ) Email

Primary Insurance

Reason for visit : ____________________

Current health concerns or conditions:____________________

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Were you referred to us? By whom? ____________________

MEDICATIONS & HEALTH PROBLEMS

List ALL prescription or over-the-counter medications and supplements you take.

____________________ ____________________

____________________ ____________________

____________________ ____________________

Please list any previous surgeries or hospital visits and approximate dates.

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List all doctors, specialists, imaging, etc. you have had in the past five years.

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When & where was your last annual wellness exam and/or labs performed?

____

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	ADHD	☐	☐	constipation	☐	☐	high cholesterol	☐	☐	nerve pain/numbness
☐	☐	allergies (seasonal)	☐	☐	COPD	☐	☐	hi blood pressure	☐	☐	obesity
☐	☐	anemia	☐	☐	depression	☐	☐	hormone problems	☐	☐	osteoporosis
☐	☐	anxiety/stress	☐	☐	diabetes	☐	☐	insomnia	☐	☐	reflux / GERD
☐	☐	arthritis	☐	☐	fibromyalgia	☐	☐	kidney problems	☐	☐	seizures
☐	☐	asthma	☐	☐	GI problems	☐	☐	kidney stones	☐	☐	skin problems
☐	☐	back pain	☐	☐	gout	☐	☐	liver problem	☐	☐	sleep apnea
☐	☐	bladder problems	☐	☐	headaches	☐	☐	mental illness	☐	☐	stroke
☐	☐	cancer __________	☐	☐	heart disease	☐	☐	menopause	☐	☐	substance abuse
☐	☐	CHF	☐	☐	hepatitis	☐	☐	muscle/joint pain	☐	☐	vision/eye problems
☐	☐	__________	☐	☐	__________	☐	☐	__________	☐	☐	__________

Please include details about **ALL** conditions checked above and who is treating them.

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Patient signature Date