

INFINITY FAMILY PRACTICE NEW PATIENT PREVIEW FORM

Full Name _____ Date of Birth _____

Phone _____ Email Address _____

Address _____

Insurance _____

Current Physician _____

Current Medication Listings (top 4 if more than 4)

Diagnosed Medical Conditions (i.e. diabetes, high blood pressure, high cholesterol, etc.)
(top 4 if more than 4)

Is the patient being seen at a pain clinic for any chronic conditions: YES NO

PLEASE BE ADVISED INFINITY FAMILY PRACTICE DOCTORS DO NOT PRESCRIBE ANY NARCOTICS OR CONTROLLED SUBSTANCES.

IN ORDER TO MAKE CERTAIN WE FIND THE BEST AVAILABLE APPOINTMENT FOR OUR PATIENTS THIS FORM WILL BE GIVEN TO THE NURSING STAFF FOR REVIEW WITH THE PROVIDER. YOU WILL RECEIVE A CALL FROM OUR OFFICE ONCE AN APPOINTMENT TIME IS DETERMINED. THANK YOU.

