GEARY COMMUNITY HOSPITAL
REQUEST FOR NEW PRIMARY CARE PROVIDER

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Former Last Name (If any)	Last 4 of SSN

Date:	Primary Language:	Date of Birth:	Sex:	Primary Phone Number:

Street Address:	E-mail:

P.O. Box:	City:	State:	ZIP Code:

Do you have a preference to who you see for your medical care? No Yes:

Reason you are seeking a new primary care provider?

Are you seeing any Specialist? (ie. Neurology, Urology, Nephrology)

Parent/Guardian (If minor)	Birth date:	Primary Phone Number:

Address (if different):	Is this person a patient here?

Indicate primary need for appointment.

- Need to establish care - No urgency
- Needs medication refills
- Need urgent treatment - (In pain or currently sick)
- Need to be seen for chronic or established medical diagnosis
- OTHER:

What current medical conditions have you been seen for in the past? (Primary Diagnosis Surgical History) ______

______

Current Medications(s): Name	Dosage	Frequency

What Pharmacy do you prefer? ______

(May use reverse side if needed)

Updated 10/04/2018