# New Patient Request Form

**Patient's Name:** ________________________________________ **DOB:** _____________

**Provider Requested:** ____________________ **Current PCP:** ___________________

**Date Requested:** __________________

**Reason for wanting to be seen:** ______________________________________________

**Please list ALL current medications:**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

**Please list all medical conditions:**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

**Please list any recent hospitalizations/outpatient procedures:**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

**Please list any Specialists seen:**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

**Comments:**

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

**Patient Signature**

**Administrative use only below this line**

_________________________________________________________________

**HS Account # ____________________**

**Approved □** **Declined □**

**Reason for being declined:**

_____________________________________________

**Insurance**

_________________________________________________________

**Signature ___________________________** **Date _________________**

***Once determination is made, send a copy of this sheet to Administration for tracking purposes***