Date:_______________ Initials of staff_____________

NEW PATIENT INTAKE FORM

Patient Name: ____ Gender: M F Birth Date:________________________

Address/City: ____

Phone Number:_____________________________ May we leave a message? YES NO

Guardian/Power of Attorney:______________________________ Relationship ________________ Phone:________________

Emergency Contact:_______________________________Relationship________________________Phone:_________________

DOCTOR PREFERENCE:

☐ **FAMILY DOCTOR:** Preferred:
☐ **INTERNAL MEDICINE:** Preferred:
☐ **PSYCHIATRY**

Are you currently under treatment by any doctor?

No

Yes

If yes, what do they specialize in?

MEDICAL INFORMATION:

Past Doctor/Clinic:_________________________City/Address/Phone:_____________________________

Reason for Changing?:____

Current Health Concerns:____

Surgeries in Last 3 Year:____

Medications:____

Current Pharmacies:____

☐ **OB CURRENTLY PREGNANT: LAST MENSTRUAL PERIOD:**

Number of Pregnancies: Number of Living Children: Prior C-sections? NO YES

Issues with past pregnancies: ____________________ City/Address/Phone_______________________

Current OB Doctor:____

City/Address/Phone: ____

Reason for Change?:____

FORWARD COMPLETED FORM TO: Greater Regional Medical Clinic 1700 W. Townline Creston, IA 50801

For Office Use Only:

Provider	Yes	No	Comments	Date/Time
Dr. Hoyt	☐	☐	Comments:______________________	Date/Time____________
Dr. Preston	☐	☐	Comments:______________________	Date/Time____________
Dr. K. Bolinger	☐	☐	Comments:______________________	Date/Time____________
Dr. Walker	☐	☐	Comments:______________________	Date/Time____________
Dr. Miller	☐	☐	Comments:______________________	Date/Time____________
Dr. Brown	☐	☐	Comments:______________________	Date/Time____________
Dr. Reeves	☐	☐	Comments:______________________	Date/Time____________
C. Johnson ARNP	☐	☐	Comments:______________________	Date/Time____________
B. Waltersdorf PA.C	☐	☐	Comments:______________________	Date/Time____________

Assigned To: _________________ Appt Needed? Yes ☐ No ☐ Sent to Phone Nurse:____________ Answered Pt to VM Date/Time______________

Patient notified of Decision via: ☐ Phone ☐ Voicemail By: ___________ Date/Time______________

September 2017