Date: ____________ Staff initials: _______

Appointment Sheet

Name: ____ DOB: _________________________

Address: ____

Phone Number: ____

Insurance Name:______________________ Contract Number:__________________________________

Group Number: _____________________________Effective Date: _____________________________

Policy Holder's Name: _____________________________Policy Holder's DOB: _______________________

Reason for appointment:____

Medical History: (Include previous **Primary Care Physician** and **Specialists**)

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____

Medications: List each medicine and the dosage.

(Will NOT schedule appointment without knowing all medicines the patient is taking.)

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Primary Care office use ONLY

______ Bring to your appointment: **medicine bottles, driver's license, insurance card and copay**.

______ Arrive 10-15 minutes early to fill out new patient paperwork.

______ Patient aware of No Show/day of appt canceled fee of $25.

Credit Card (Once Appointment is MADE)

Name on Card: ____

Card Number: XXXX XXXX XXXX XXXX Expiration Date: ____/_______ CCV_______