NEW PATIENTS

***** MUST BRING PATIENT'S PHOTO ID (18 & older) & INSURANCE CARDS WITH THIS FORM *****

PLEASE CHECK BY THE NAME OF THE DOCTOR YOU WOULD LIKE TO SEE

☐ J. Gregory Elders M.D. ☐ George S. Lawrence M.D. ☐ Lonnie S. Robinson M.D. ☐ Andrea N. Bounds M.D.

☐ Ronald F. Bruton M.D. ☐ Sharon Jamie Pritchard M.D. ☐ Alex S. Hagaman D.O. ☐ Hannah G. McCarthy M.D.

Patient Name: ________________________/________________________________
(Name of parent or guardian)

Date of Birth: ______________________ Social Security Number: _______________

Patient's COMPLETE mailing Address: ____

Daytime Phone Number: ____

Medications: ____

____

Controlled Substance (Rx): ____

____

Medical Issues: ____

____

Insurance Info: ____

Do you have family members established with one of our doctors? YES NO
If yes list names of family members____

____

Are you already established with another provider?

Who? ________________________ Where? ____________________________

Have you ever been a patient of Regional Family Medicine in the past? If so who was your Provider? ____

Date: _________________ Received by Staff Member:____________________