



NEW PATIENT APPLICATION

PLEASE COMPLETE ALL QUESTIONS

Today's Date: ____ / ____ / ____ Preferred Name: _____

Legal Name: _____ Birthdate: ____ / ____ / ____

Phone: _____ Email: _____

Address/City/Zip: _____

Preferred Pronouns: ____ She/Her ____ He/Him ____ They/Them ____ Other

Gender Preference: ____ Male ____ Female ____ Non Binary ____ Transgender

____ Prefer Not To Answer ____ Other

How did you hear about our office? _____

Current Medical Conditions:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Current Medication List for Conditions:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

7) _____ 8) _____ 9) _____

10) _____ 11) _____ 12) _____

Please complete a separate New Patient Application for any immediate family members who would like to join with you.

Provider Preference: ____ Alan J Conrad, MD ____ Dominic J Kiomento, MD

____ Anne L Broad, MD ____ Kayla M Stefanko, DO ____ Tania M LeBaron, MD

____ Scott A Philburn, PA-C ____ Ryan A Straight, PA-C ____ Amy R Schroeder, FNP-C



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PLEASE COMPLETE ALL QUESTIONS**

Insurance (Primary): _____ Copay Amount: _____

Subscriber Name: _____ Birthdate: ____ / ____ / ____

ID#: _____ GROUP #: _____ SSN: _____

Effective Date: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

Insurance (Secondary): _____ Copay Amount: _____

Subscriber Name: _____ Birthdate: ____ / ____ / ____

ID#: _____ GROUP #: _____

Effective Date: ____ / ____ / ____ Expiration Date: ____ / ____ / ____

COMPLETION of new patient application does not guarantee acceptance as a patient with a provider at Cadillac Family Physicians PC.

MISREPRESENTATION of information provided may jeopardize the patient relationship with Cadillac Family Physicians PC.

Please return the application(s) to the office, send via mail to Cadillac Family Physicians PC, Attn: Scheduling, 8950 Professional Drive, Cadillac, MI 49601 or Fax to: (231) 779-7701

Office use only:

Physician Approval: _____ **Date:** _____

Records required prior to appointment? Yes ___ **No** ___