



# NEW PATIENT APPLICATION

## PLEASE COMPLETE ALL QUESTIONS

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Preferred Name: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address/City/Zip: \_\_\_\_\_

Preferred Pronouns: \_\_\_\_ She/Her \_\_\_\_ He/Him \_\_\_\_ They/Them \_\_\_\_ Other

Gender Preference: \_\_\_\_ Female \_\_\_\_ Male \_\_\_\_ 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: **Non-disclosure of controlled medications may result in dismissal**

- 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:** \_\_\_\_ Amanda M. Stark, DO \_\_\_\_ 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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**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** \_\_\_