Greater Regional HEALTH

PHI Released ____

MRN:

Date: ________________ Initials of Staff: ____________

New Patient Intake Form- Clinics

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

Address: ____________________________ City/State: _______________ Zip: ___________ County: _________________

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

Emergency Contact:______________________________Relationship________________Phone: _____________________

DOCTOR PREFERENCE:

- ☐ FAMILY MEDICINE: Preferred:
- ☐ INTERNAL MEDICINE: Preferred:
- ☐ PSYCHIATRY – Info on back

CLINIC LOCATION PREFERENCE:

☐ CRESTON ☐ LENOX ☐ MT. AYR ☐ CORNING

MEDICAL INFORMATION:

Past Doctor/Clinic: _______________________________ City/Address/Phone: __________________________________

Goal from your new provider that your current one is not providing you: ____

____

Current Health Concerns: ____

Chronic Illnesses/Continuing Medical Conditions: ____

____

____

Surgeries in Last 3 Year: ____

Medications: ____

Specialty Providers:____

**Please note you may be referred to a specialist if your PCP is unable to meet medical needs.

Current Pharmacies: ____

PCP: ___________ Appt Needed? ☐ Yes ☐ No Sent to Phone Nurse: _________ Answered Pt to VM Date/Time_____________

Patient notified of Decision via: ☐ Phone ☐ Voicemail By: __________ Date/Time_____________

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Emergency Contact: ________________________________ Relationship____________________ Phone: ______________

☐ PSYCHIATRY

☐ LeeAnn Berg, ARNP ☐ Dr. Preston, MD

Current Psychiatrist: ___________________________ City/Address/Phone: _______________________________________

Past Psychiatrist/How long ago: ___________________________________ City/Address/Phone: _____________________

Reason for Changing: ____

____

Current Concerns/Diagnosis: ____

____

Medications: ____

____

Primary Physician: ____

Referred By: ____

Psych Provider: __________ Appt Needed? ☐ Yes ☐ No Answered Pt to VM Date/Time___________

Patient notified of Decision via: ☐ Phone ☐ Voicemail By: ___________ Date/Time___________ Referral ☐ Yes ☐ No