Family Practice New Patient Information Questionnaire
OFFICE USE HX:

Name	Today's Date
DOB	GENDER at Birth:
SS	
Address	
City, State and ZIP	
Phone Number	
Email	
Primary Insurance	Po Box Back of Card
Subscriber Name and DOB	EFFECTIVE DATE
Id#	Group#
Office Copay $	Specialist Copay$

Secondary Insurance	Po Box Back of Card
Subscriber Name and DOB	
Id#	Group#
Office Copay	Specialist Copay

Is there a Specific Doctor you would like to Est Care With?

If No, do you prefer Male or Female?

Current Concerns you would like to be seen for?

Who was last PCP?

Please Send Form to Tanya Foster Email: tfoster@cntllp.com EXT 5115

New Pt Line 940-766-8888. Fax 940-766-8607

Medications

Emergency Contact

Phone #

DOB

Relation

Pain Meds
YES / NO
Doctor?

Hormones
YES/NO

ADD/ ADHD
YES/NO

Depression/Anxiety
YES/NO
Doctor?