New Patient Application

This form must be complete in order to process your request.

Name:_____ Date of Birth:_____ Gender: M / F

Address:_____

City:_____ State:_____ Zip Code:_____

Phone #: Home_____ Cell_____

E-mail:_____ Social Security #:_____

Occupation:_____ Employer:_____

Health Insurance Carrier:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Current/Previous Provider:_____ Reason for Change:_____

Specialist/Other Providers:_____

Date of most recent physical:_____ Date of most recent pap:_____

Current Medications: _____

_____

Past Medical Problems/Surgeries/Hospitalizations: _____

_____

What are you looking for in a medical provider?: _____

_____

How did you hear about Woodway?: _____

Please place a check by the Provider you would prefer to see:

Dr. Robert Suer ☐ **Dr. Earl Lloyd** ☐ **Heather Hamilton, DNP** ☐ **Keri Lowe, FNP** ☐

Please be aware that we do not accept all types of insurance. Please check with your insurance carrier that Woodway Internal Medicine is in your network.

Once you have been accepted you will receive a message from the office via phone call, text message and/or email of your initial appointment time and date. Please make sure you complete all sections of this form.

Consent to call: Yes☐ No☐ Consent to Text: Yes☐ No☐ Consent to E-mail: Yes☐ No☐

This form is for informational purposes only and does not imply establishment of medical care with our facility.

Medication List Cont: _____

_____

_____

_____

_____

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