DATE:_____ CHART:_____

Patient (name as shown on insurance card):_____

Sex:_____ Home phone#_____ Cell phone#_____

Email Address:_____

Date of Birth:_____ Social Security #:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

(If patient has UHC Compass, we are not in network, you will be self pay. If you have Tricare, please list DOD # or subscribers SS #)

Primary Insurance:_____ Subscriber Name:_____

Policy #_____ Group #_____

Secondary Insurance:_____ Subscriber Name:_____

Policy#_____ Group #_____

Preferred Pharmacy:_____ City:_____

Preferred Physician:_____

2nd choice Preferred Physician:_____

Does the patient have a family member treated here? If so, who?_____

Previous Primary Care Physician:_____

Reason for switching:_____

Please list all medications and dosage:_____

_____

_____

_____

_____

Please fill out ALL fields. Ex: If you take no medications, please state none or n/a.

Once we receive your form, please allow 2-3 weeks to process.

PMA

Professional Medical Associates