Getting to Know You

Name: _____ Nickname/Goes By_____

DOB: _____ Age: _____ Gender Assigned at Birth: _____

E-mail: _____ Phone: _____

- **Have you reviewed our website? YES ☐ NO ☐**
- **Would you like to receive our Practice Newsletter? YES ☐ NO ☐**
- **What appeals to you about the practice?**

  _____

- **Preferred Pharmacy _____ Phone_____**

  Address_____

- **Prior Primary Care Physician**

  Dr.'s Name:_____ Office Phone_____

  City_____

  Approximate Date(s) of Care:_____

- **Other Specialists in the past 5 years?**

  Dr.'s Name:_____ Office Phone_____

  City_____ Date(s) of Care:_____

  Dr.'s Name:_____ Office Phone_____

  City_____ Date(s) of Care:_____

  Attach additional Page if needed

- **Do you have insurance? If Yes, please list insurance company name:**
  _____
- **Is your insurance an HMO? _____**
  If YES, please be aware that we are not able to accept you as a primary care patient at this time. Please contact us if you need further information