NEW PATIENT APPLICATION

Name: _____ DOB: _____
Phone: _____ Age: _____
Insurance: _____ Date: _____

Do you see a medical provider? __Yes __No
If yes, what medications are prescribed for you?

_____
_____
_____
_____
_____
_____

Do you see a psychiatrist/psychologist? __Yes __No
If yes, what anxiety, nerve, or sedative medications are you prescribed?

_____
_____

Are you in a pain management program? __Yes __No
If yes, what pain medications are prescribed for you?

_____
_____

Please list any surgeries

_____
_____
_____
_____

Please list any past medical history

_____
_____
_____
_____
_____

FOR OFFICE USE ONLY: OARRS Completed ____ _____ Date _____
Accepted(Y/N): _____ Practitioner: _____ Date _____
Appt. Date: _____ Date Pt. Notified: _____