



## New Patient Request Form

Welcome to Rolling Hills Clinic! Please take a moment to fill out the following information as thoroughly and honestly as possible so that we may give you the highest quality care. Please let us know if you need assistance or have any questions.

### 1. Patient Information

_____	_____	_____	_____
Last Name	First Name	Date of Birth	Phone
_____		_____	_____
Home Address		City	State Zip
_____		_____	_____
Mailing Address		City	State Zip
_____		_____	_____

### 2. Drugs & Medications

Are you taking any prescription or non-prescription medication? If you have more medications or cannot remember their names, please bring all your prescription bottles or a current list of your medications.

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

### 3. Allergies

Please list any allergies you may have to food, drugs, or other substances.

\_\_\_\_\_

\_\_\_\_\_

### 4. Medical Problems

Please list each medical problem that you are experiencing.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 5. Your Previous Care

- a) Who was your previous doctor? \_\_\_\_\_
- b) What specialists do you see? \_\_\_\_\_
- c) Why are you changing doctors? \_\_\_\_\_

### 6. Which Clinic location would you prefer?

Corning       Red Bluff

### 7. Please provide a copy of your insurance card, front and back.

#### Official Use Only:

Notes:

RECEPTION: Received by: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN: Patient  Accepted  Denied Date: \_\_\_\_\_