JONESVILLE FAMILY MEDICAL CENTER, P.A.

New Patient Request

Name(s) & Birthdate(s) _____

_____

_____

Social Security Number(s) _____

_____

_____

Address _____

_____

_____

Phone _____

Insurance Coverage(s) _____

_____

NOTE:

- In order to verify that your insurance is one in which we are currently participating, please submit a **COPY** of your insurance cards with this application.
- Page 3 is a Release of Medical Records form. This is an authorization for your present Physician to release your records **in the event** we are able to take you as a patient. By signing this form now, this will prevent your having to come back here to sign a release form, if we are able to take you as a patient. We are unsure at this time how many patients we will be taking. We will notify you first, and then send for your records.

JONESVILLE FAMILY MEDICAL CENTER, P.A.
New Patient Request Form

Please list any chronic medical conditions for which you are currently receiving treatment:

_____

_____

_____

_____

Please list all current medications, dosage of medications, frequency and number per day:

_____

_____

_____

_____

What other doctors or clinics do you see regularly?

_____

_____

_____

_____

Why are you interested in our practice/Why are you changing physicians?

_____

_____

_____

_____

Jonesville Family Medical Center, P.A.

4000 South Swaim Street Ext.
Jonesville, NC 28642
(336)835-6300

Date _____

I, _____,

Date of Birth _____,

Social Security # _____,

do hereby consent and authorize:

Physician or Facility _____,

Address _____,

City _____State _____Zip _____,

to release a complete copy of the medical record(s) relating to my identity, diagnosis, prognosis and treatment, including but not limited to treatment of drug and alcohol related illness, psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

Problem List (or a list of the patient's chronic conditions and most recent acute problems, if one exists), Medication list, Progress Notes for the last 2 years, Lab records (most recent), Last Hospital Admission and Discharge summaries, X-ray reports (last 2 years), Stress tests (last 2 years), Immunization Records, _____

_____.

Please forward these records to the Jonesville Family Medical Center, PA at the address listed above.

Patient's Signature _____

Witnessed by _____