Sunshine Family Care Clinic

NEW PATIENT
REQUEST TO ESTABLISH FORM

Today's Date: _____

Full Legal Name: _____ Previous Last Name: _____
Last, First MI

Date of Birth: _____/_____/_____ Birth Gender: Male ❒ Female ❒

Please indicate your preferred method of contact:

Mailing Address: _____ Home Phone: ❒_____
City: _____ Cell Phone: ❒_____
State/Zip: _____ Work Phone: ❒_____
Email Address: _____ Fax Number: ❒_____

Please indicate who referred you:

❒ Self ❒ Health Department ❒ Primary Care Provider

❒ Other (please indicate) _____

Please briefly list your medical history: _____

_____

_____

Please list your current medication list, including current strength and how you take it: _____

_____

_____

_____

_____

(Attach list or include additional pages if needed.)

We will be contacting you shortly on your request.
Please allow 5-7 days for response. Thank you for your interest.

For Office Use Only

Date contacted above: _____

Date completed form received in office: _____

Date this form sent to above for completion: _____

Decision regarding request: _____