

## APPLICATION FOR ACCEPTANCE AS A PATIENT OF MT. STERLING CLINIC, PLLC

Please answer all questions as accurately as possible. After completing this form, please return it to the Mt. Sterling Clinic. You will be notified within 2-3 weeks after returning this form of your acceptance or decline as a patient of this practice.

Patient name \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Address \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
\_\_\_\_\_

Phone number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Prior Primary Care Physician \_\_\_\_\_

Reason for transfer of care \_\_\_\_\_

List ALL insurance coverage you have:

Primary \_\_\_\_\_ Policy Number \_\_\_\_\_

Secondary \_\_\_\_\_ Policy Number \_\_\_\_\_

Medical Conditions you require treatment for:

\_\_\_\_\_  
\_\_\_\_\_

Do you require treatment/medication for chronic pain \_\_\_\_\_yes \_\_\_\_\_no

List ALL medications you take on a regular basis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and relationship of person who referred you to this practice:

\_\_\_\_\_  
name relationship

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**EACH QUESTION MUST BE ANSWERED IN ORDER FOR YOUR APPLICATION TO BE  
REVIEWED. INCOMPLETE FORMS WILL BE RETURNED TO YOU FOR COMPLETION.**