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
Please note that the Mt. Sterling Clinic does not provide chronic pain medications. Patients who require chronic pain medications will be referred to a pain clinic for treatment and refills.

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.

THANK YOU!