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 along with a copy of your insurance card(s). You will be notified as soon as possible after returning this form of your acceptance or decline as a patient of this practice.

Patient name _____ AGE _____DATE OF BIRTH _____

Address _____

Phone number _____ Alternate phone number _____

Social Security Number _____ _____ Male ___ Female

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. Patientswho 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_____

A COPY OF YOUR INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM.

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

THANK YOU!