New Patient Request Form

Patient Demographics

Patient Name (as it appears on Insurance card): _____ DOB: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Primary Insurance

Insurance carrier: _____ Subscriber ID: _____

Group #: _____ Subscriber Relationship: _____

Subscriber DOB: _____

Secondary Insurance

Insurance carrier: _____ Subscriber ID: _____

Group #: _____ Subscriber Relationship: _____

Subscriber DOB: _____

Medical History

Please list all current prescription medications:

_____

_____

_____

_____

_____

In the last 6 months have you been treated for chronic pain at a pain? Yes ____ No ___

Previous Primary Care Physician: _____

Office Name and Address: _____

Physician Preference:

□ **Dr. Villarreal** □ **Dr. Kelly Shedd** □ **Harold Fite, PA**

The above information is true to the best of my knowledge.

Failure to disclose pertinent medical information may result in dismissal from the practice.

Signature: _____

Please submit this form via email to internalmedgastonia@gmail.com OR submit it in office at 2391 Court Dr. Suite #110 Gastonia, NC 28054