2005 C PIONEER ST
WAYCROSS, GA 31501
PHONE: (912) 490-7777
FAX: (912) 490-7778

NEW PATIENT APPLICATION

NAME: _____ DOB: _____ GENDER: _____

ADDRESS: physical: _____ mailing: _____

CITY: _____ STATE/ZIP: _____ PHONE # _____

EMPLOYER: _____ EMPLOYER # _____

ADDRESS: _____

INSURANCE: PRIMARY: _____ SECONDARY: _____

PREFERRED PROVIDER (CIRCLE ONE) (PCP)

Bradley Page PA-C Roxy Sheffield PA-C Leanna Lewis FNP

Dillon Veal PA-C Tayler Allen, PA-C

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____
WHO REFERRED YOU TO OUR PRACTICE? _____
REASON FOR VISIT: _____

PAST MEDICAL HISTORY/PROCEDURES:

_____

_____

_____

PAST TRAUMA HISTORY:

_____

_____

_____

CURRENT MEDICATIONS: Please list all current medication. -ATTACH A LIST IF NEEDED

_____ _____

_____ _____

_____ _____

SIGNATURE (PATIENT OR GUARANTOR): _____ DATE: _____

OFFICE USE: RECEIVED BY: _____ DATE: _____

SEND A COPY OF YOUR INSURANCE CARD WITH APPLICATION

*Please be advised that we do not prescribe chronic pain medication at this practice. *

*As of 10/10/2024 Please understand ALL New Patient appointments are required to pay deposit of $50 AT THE TIME OF SCHEDULING & if you No-Show, that is NON-REFUNDABLE. *