**New Patient Request Form**

**Office Address**: 1250 N Vantage Point Drive, Crystal River, FL 34429 **O:** 352.795.0644 **F:** 352.795.5950

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_ **DOB**: \_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Alt Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Ryan Dickert, MD | Coty Tino, MD | Josef Plum, MD | Kaitlyn Dickert, PA |
| Alex Dickert, MD | Jennifer Yoho, PA | Meghan Trenary, ARNP |  |

**Patient Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip** **Code:** \_\_\_\_\_\_\_\_\_

**Medical Issues: REQUIRED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List of ALL Medications: REQUIRED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Controlled Substances (Check All That Apply):**

|  |  |  |
| --- | --- | --- |
| * Hydrocodone | * Fentanyl | * Morphine |
| * Oxycodone | * Tramadol | * Other\_\_\_\_\_\_\_ |

**Pain Management Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| * Xanax/Alprazolam | * Ativan/Lorazepam | * Other \_\_\_\_\_\_\_\_\_\_ |
| * Diazepam/Valium | * Klonopin/Clonazepam |  |

**Reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:** \_\_\_\_ Medicare Parts A & B \_\_\_\_BCBS \_\_\_\_ Self-Pay \_\_\_\_ Tricare

\_\_\_\_Ultimate HMO (Managed Care Team) \_\_\_\_ Humana HMO Gold (Managed Care Team)

**Insurance Member ID #: REQUIRED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Taken:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Taken By**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Approved By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Team: (Managed Care)**

Date of Last: Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Performed Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_