New Patient Application

Perry Medical Clinic, P.C.
Your Healthcare, Our First Priority.

Date: _____

Patient Demographics

_____ _____ M F
Patient Name Patient's Date of Birth Age Gender

_____ _____
Address Spouse/ Parent/ Guardian Name– Include Date of Birth & SSN

_____ _____
City/ Zip Patient's SSN

_____ _____ _____
Primary Phone Secondary Phone Email

☐ **W. Barton Perry** ☐ **Clinton J. Allen**

_____ ☐ **Sheri A. Frickey** ☐ **Joy Allen, CRNP**
Previous Physician Name

_____ ☐ **Haley Trammell, CRNP** ☐ **NO PREFERENCE**
Reason for Changing

Medical Information

_____
Medical Problem that Needs Attention Now

_____
Past Medical History (Example Hypertension)

_____
Current Medications

BILLING INFORMATION

PRIMARY INSURANCE

Name of Insurance:_____

Contract #:_____ Group #:_____

Name of Policy Holder:_____ Policy Holder's Date of Birth:_____

Relationship to Policy Holder:_____

SECONDARY INSURANCE

Name of Insurance:_____

Contract #:_____ Group #:_____

Name of Policy Holder:_____ Policy Holder's Date of Birth:_____

Relationship to Policy Holder:_____

RESPONSIBLE PARTY

Responsible Party's Name:_____ Social Security #:_____

Office Use Only

Account_____

WBP_____ ☐A ☐D Patient Contact:☐Phoned ☐ Emailed- Portal Invite ☐

SAF_____ ☐A ☐D Date:_____ Initials:_____

CJA_____ ☐A ☐D Comments:

HJT_____ ☐A ☐D JHA_____ ☐A ☐D