New Patient Application

PERRY Medical Clinic

Patient Name:_____

Social Security Number:_____

Date of Birth:_____ Gender: M / F

Marital Status:

Single Married Divorced Widowed Legally Separated

Ethnicity: (circle one)

White African American Asian Other

Address:_____ Primary phone:_____

City/State/Zip:_____Secondary Phone:_____

Spouse/Parent/
Guardian:_____Social Security Number: _____Date of Birth:_____

Previous Primary Care

Physician:_____

Address and Phone Number:_____

_____

Reason for Changing:_____

Provider

☐ W. Barton Perry, M.D ☐ Clinton Allen, M.D

☐ Sheri Frickey, D.O

☐ Haley Trammell, CRNP ☐ Joy Allen, CRNP

☐ No Preference

Medical Information

Medical problems that need attention now: _____

Past medical History(example: Hypertension; Diabetes):_____

Medications

Dosage and Instructions

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Billing Information

Primary Insurance

Name of Insurance:_____

Member I.D:#_____Group #:_____

Name of Policy Holder:_____

DOB of Policy Holder:_____

Relationship to Policy Holder:_____

Secondary Insurance

Name of Insurance:_____

Member I.D:#_____Group #:_____

Name of Policy Holder:_____

DOB of Policy Holder:_____

Relationship to Policy Holder:_____

Responsible Party

Name:_____ DOB:_____ SSN:_____

Billing Address:_____

Account Balance:_____

For Office Use Only

WBP:_____ Y N HJT:_____ Y N

SAF:_____ Y N JHA:_____ Y N

CJA:_____ Y N

Patient Contacted via: Phone ☐
e-mail ☐
Portal invite ☐

Date:_____Initials:_____

Comments:_____