New Patient Request Form
Hanover Family Practice Associates, LLC

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Filled in by: **Date:**

Name: **Date of Birth**:

Telephone: **Email Address:**

Address:

How long have you lived in the Hanover Area?

Will you allow permission to review medical records currently available in our shared Electronic Health Record?

Yes: ☐ **No:** ☐

Place of Employment:

Health Insurance Coverage:

* Self-Pay patient cost begin at $93.60. The cost will increase depending on the complexity of the visit and with any additional orders or testing required. Payment is expected to be paid in full at the time of service.

Preferred Provider: Male ☐ / Female ☐ / No Preference ☐

Current Family Physician:

OB-GYN (If applicable):

Eye Care Professional (If applicable):

Reason for Change:
How soon do you need to be seen?
What specifically do you need to be seen for?
Major Medical Problems (Chronic Conditions)**:**
Medications:

***Hanover Family Practice Providers will assess if it is appropriate to continue any Narcotics or Benzodiazepines you may currently be prescribed.*

Are you current with vaccinations? Yes: ☐ **No:** ☐ **Not Sure & Interested:** ☐ **Not Sure & Not Interested:** ☐

Last Wellness Visit (Preventive Visit, MWV or AWV)?

Who referred you?

Provider Response (Initial here) : NO: _____ _____ _____ _____ YES:_____