POSSIBLE NEW PATIENT FORM

1951Bench Rd, Ste. B
Pocatello, ID 83201
Phone: 208.238.1000 Fax: 208.238.0009

Date: _____ Doctor: _____

Name: _____DOB: _____/_____/_____(Age:_____)

Address: _____

City: _____State: _____ Zip Code: _____

Phone Number(s): _____home _____cell _____work

Insurance Carrier(s): _____

Referring Physician: _____ Other: _____

Any Family Members Seen At IMMC: _____

Diagnosis:_____

Medications: _____

_____

Complaint(s): *please circle all that apply*

Anemia	Cancer	Heart	Kidney/Bladder	Wellness
Anxiety	Colitis	Hypertension	Menstrual Problems	Skin Problems
Asthma	Diabetes	Hay Fever	Mental Illness	Thyroid Problems
Arthritis	Epilepsy	Hepatitis	Phlebitis	Ulcers

Other problems/symptoms: _____

_____

Duration of problems/symptoms: _____

_____

Comments: _____

_____

_____

_____