ESTABLISHED PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____ DOB:____/____/_____

Address:_____ City:_____ State:_____

Zip:_____ Home Phone:_____ Cell Phone:_____

Social Security Number:_____ Email:_____

My Favorite MY DR NOW Provider Is:_____ My Last Annual Physical Was On:____/____/_____

INSURANCE INFORMATION

Changes? ☐ Yes ☐ No

Insurance Name:_____

Policy#:_____ Group#:_____

Policy Holder Name:_____ Policy Holder DOB:____/____/_____

SECONDARY INSURANCE INFORMATION

Insurance Name:_____

Policy#:_____ Group#:_____

Policy Holder Name:_____ Policy Holder DOB:____/____/_____

RESPONSIBLE PARTY

I have read and understand MY DR NOW's clinic & financial policies. As a valued patient of MY DR NOW, I understand appointments aren't a requirement and I can walk in for care at my convenience, but a $25 fee will be assessed for appointments cancelled within 24 hours of the scheduled time. I request the practice utilizes all methods of communication provided to discuss my healthcare.

Signature _____ Date: _____/_____/_____

Have You Joined Our Patient Portal?

Visit www.MYDRNOW.com to sign up for your secure Patient Portal where you can schedule appointments, make a payment, request medical records, renew prescriptions, and much more.