PREMIER INTERNAL
MEDICINE ASSOCIATES, PC

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New Patient Application

Name: ______________________________ DOB: _______________

Phone Number: __________________________

How did you hear about us? _____________________________________

Who is your primary insurance? ____

Who is your current or previous primary physician? ________________________

Please list all chronic illness:

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Please list all current medications:

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Please list all specialists you see:

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Please note that we do not manage chronic pain or see patients under 18 years of age.
This form can be dropped off at our front desk, faxed, or mailed to us.
We look forward to meeting you!

premierintmed.com
Fax: 256-265-1911