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Request to Establish Care **Spartanburg** **Greenville** **Columbia** **Drayton Mills**

Name: _____ DOB: _____

Phone number(s): _____ Email: _____

Address: _____

Who was your previous primary care physician? _____

Medical history or current diagnosis of the following (check below):

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Anxiety / Depression

Other health issues not listed above: _____

What medications do you take, if any?

Do you understand we do not manage chronic pain? Yes No

Would you like to become a P3 member? Yes No I would like more info

Who referred you to our office? _____

Do you have a close friend or relative who is currently a patient here? Yes No

Who: _____

**** In order to keep our prices affordable while continuing to practice excellent medical care, we do not file or accept payment from insurance companies. We ask that payments for all services be made by cash or credit card prior to leaving the office. At this time, we do not set up billing or arrange payment plans (other than our P3 program), nor do we accept checks. If you have medical insurance, let us know so we can provide you with an itemized bill that you may submit to your insurance company to see if they will apply it towards your deductible or reimburse a portion of the charges (there is no guarantee that your insurance company will do either of these).