WEST FLORIDA MEDICAL ASSOCIATES, P A / BELLAM MEDICAL CLINIC

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NEW PATIENT QUESTIONNAIRE/SUBOXONE

PT.NAME:_____ D/O/B: _____

PHONE#: _____ LAST FOUR SSN: XXX------XX--- _____

ADDRESS: _____

1. HEALTH PROBLEMS:_____

_____

2. LIST ALL MEDS: _____

_____

3. ANY HOSPITAL ADMISSIONS OR ER VISITS IN LAST 6 MONTHS: **YES** **OR** **NO**

4. ANY CONSULTANT –DOCTORS SEEING NOW OR PLANNING TO SEE : _____

_____

5. PREVIOUS DR: _____

6. PHARMACY: _____

7. INSURANCE INFO.:_____ INFO TAKEN BY & DATE_____

APPROVED: ____YES ____ NO _____ DR.INITIALS

INFORM EVERYONE OUR PROVIDERS WILL DECIDE MEDICAL CARE NEEDED AFTER THE VISIT ABOUT ANY CONSULTATION-REFERRALS OR PRIOR AUTHORIZATIONS
ASK PATIENT : IS IT FOR ROUTINE PHYSICAL OR ANY SICKNESS NOW,
ALSO NEEDS LIST OF ALL MEDICATIONS INCLUDING PAIN MEDICINES IF ANY TAKING.