Collaborative Health PARTNERS

New Patient Request Form

Please provide the following information to help us determine if we have a provider that can accommodate your needs:

Name: _____ Preferred First Name *(if different)*: _____

Address: _____ City, State, Zip: _____

❑ Male ❑ Female Date of Birth: _____ SSN: _____

Home phone: _____ Work: _____ Cell: _____

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Note: Please include a copy of your insurance card(s) front and back

How did you hear about us: _____

Medical History: _____

_____

Current Medications Prescribed: _____

_____

Current Over Counter Medications: _____

_____

If a minor, are vaccines current? ❑ Yes ❑ No

Current Primary Care Provider: _____

Reason for Changing Providers: _____

Current Specialty Provider(s): _____

Provider or Office Requesting: _____

Please return this form via mail or fax:

CVFP Administration / Attn: Felicia Templeton / PO Box 307 / Forest, VA 24551

Fax: 434-525-6738

For questions about the status of your request, please contact the requested office

Office Use Only

Date Processed: _____ Processed By: _____

Patient Accepted by: _____ Date Contacted: _____

Implemented: 09/12/18

Revised: 10/27/25