New Patient Application for Daniel W. McGrane MD

Patient Name____ Date of Request______________

Address:____

Phone Number____________________________________ Birthdate______________________________

Who referred you to Dr. McGrane____

Primary Insurance____

Secondary Insurance____

Name of your current Physician___________________________________ Date of Last Visit__________

What other Physicians or specialist do you want to continue to see_____________________________

Do you have with you the records from your previous Primary Care Physician____________________

Do you have a Medical Problem which requires you to see a physician right away?________

If YES What is the reason you need to be seen right away?______________________________________

Please list all your current
medications____

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Do you require placement in a skilled nursing facility or ACLF?_________________________________

Patient Signature____ Date_______________

I am sorry we are unable to accept you into our practice____

We would be happy to accept you as our patient. I (Daniel W. McGrane MD) work with two nurse practitioners: Ms. Amanda Sturgeon ARNP and Mr. Jonathan Schamaun ARNP. Your initial visit will be scheduled with the ARNP. For the initial visit we require that you bring with you records from your previous Primary Care physician, all of your current medication bottles.

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Daniel W. McGrane MD Date

INTERNAL USE: Initial visit scheduled:____________________