NEW PATIENT QUESTIONNAIRE

Please return this questionnaire to
Orlando Matias D.O., P.C. 2104 Jolly Rd Suite 290 Okemos MI 48864.

Patient Name: _____

DOB: _____ Phone Number: _____

What insurance do you currently have: Primary _____ Secondary _____

What is your insurance Enrollee ID Number: _____

Are you looking for a new primary care physician due to
a Workman's Comp Claim or Auto Accident Case? (please circle) YES NO

Are you currently on any narcotics or pain medications? (please circle) YES NO

If yes, what medications? (please include names & dosages) _____

_____

Are you currently taking any other medications, prescribed or over-the-counter? YES NO

If yes, what medications? (please include names & dosages) _____

_____ _____

_____ _____

_____ _____

Do you have any chronic pain issues? (please circle) YES NO

If yes, what conditions? _____

Please list any other chronic conditions (ex: diabetes, high blood pressure, depression, etc.)

_____ _____

_____ _____

_____ _____

If you listed any conditions above, do you see your current primary care physician
and/or specialist every 3, 6, or 12 months for routine appointments? (please circle) YES NO N/A

Do you consider your chronic conditions well controlled? Poorly managed? Unknown? Other? Please describe: _____

Please list any other current issues or concerns

_____ _____

_____ _____

Do you follow the CDC recommended guidelines for immunizations
(ex: influenza vaccine, pneumonia vaccine, etc)? (please circle) YES NO

Do you follow the CDC recommended guidelines for cancer screenings
(mammogram, pap smear, colonoscopy, annual physical, etc)? (please circle) YES NO

What was/is the name of your previous primary care doctor? _____

What was your reason for leaving the previous doctor/practice? _____

_____

By signing, I certify all information is true and correct to the best of my knowledge.

Signature: _____ Date: _____