Wiggington Road Family Practice

New Patient Request Form

Date: ________________________

Name: ____ Preferred Name (if different): _______________

Address: ____ City/State/Zip: ________________________

Male: ________ Female: ________ Date of Birth: _____________________ SSN: __________________

Home #: ___________________________ Work: _______________________ Cell: ___________________

Primary Ins: ________________________ Policy #: ____________________ Group: _________________

Secondary Ins: ______________________ Policy #: ____________________ Group: _________________

****Please include a copy of your insurance card.**

Prescribed Medication: ____

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****<u>NOTE: We are currently at capacity with patients requiring controlled substances.</u>**

Medical Conditions:

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Current Primary Care provider: ____

Reason for Changing Providers: ____

Date of last medical care or check-up: ____

Please return this form to Wiggington Road Family Practice, 113 Wiggington Road, Lynchburg, VA 24502 or fax to 434-385-9756. Please allow 7-10 business days to respond. Thank you.