Community HealthCare System
NE Kansas

New Patient Questionnaire

Please fill out one form for each family member.

Date:

Full name:

If person is a minor, guardian's name:

Date of birth:

Address:

Primary phone number:

If person is a minor, guardian's phone number:

Who referred you to CHCS?

Who is your preferred provider?

1. Why are you seeking healthcare services?

2. What are your current health conditions?

3. What are your current prescription and non-prescription medications?

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4. Do you have any drug or food allergies? If so, please list them.

5. If you are requesting obstetrical (OB-GYN) care:
    a. What was the first day of your last menstrual period?
    b. What is your estimated delivery date?
6. Have you ever been to one of our facilities before? If so, when?

7. Who is the most recent doctor or medical provider you have seen for your healthcare needs?

By typing my initials, I attest that the above information is accurate:

Please be sure to bring a driver's license and insurance card(s) to your appointment.

For internal use only

Was the patient previously dismissed?

Reason:

Approval (check one): Yes ☐ No ☐ **Obtain records for review** ☐

Provider:

Provider: