



POTENTIAL NEW PATIENT INFORMATION

Today's Date: _____ (please allow 10 business days to process)

Do you have Monument Health Insurance? Yes or No

Did someone refer you here? Yes or No If yes, give name: _____

Full Name: _____ DOB: _____ Phone: _____

Spouse Name: _____ DOB: _____ Phone: _____

Minor Children's Names and DOB: _____

Mailing Address: _____ City: _____ Zip Code _____

E-mail Address: _____

Insurance: _____ Employer: _____

Note: Primary Care Partners does not accept Medicare Advantage Plans

Previous Physician/Provider: _____

Reason for leaving provider: _____

List ALL medications & medical indications for each: _____

Any chronic pain medications? Yes or No

If yes, for what conditions? _____

Office Use Only	
Previous Account # _____	PDMP attached none
Approved Not approved Provider initials _____	

If returning by mail please use this address:

Red Canyon Family Medicine

P.O. Box 10700

Grand Junction, CO 81502

Fax (970) 256-5290

*Please be sure to include a copy of your insurance card *