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## NEW PATIENT SCREENING FORM

**Please PRINT CLEARLY**. Note, this is only a screening form to see if we are able to see you as a new patient. We will contact you as soon as we receive your form and have a chance to review. Be aware that our Practice does not offer Pain Management options, nor do we handle Workman's Compensation or Disability cases. This form must be returned to our office via US Mail or fax (716-677-4470). After receipt and review, our office will contact you. If approved, you will need to complete the new patient packet and contact your insurance company.

Full Legal Name:_____ DOB:_____ Sex: M F

Address:_____ Non-binary

City:_____ State:_____ Zip Code:_____ Prefer To Not Say

Main Phone #:_____ Other Phone #:_____ Race:_____

Social Security # (for Billing):_____ E-Mail:_____

**Primary Insurance Company**
(Below are the Insurances our office is credentialed with, PLEASE CIRCLE YOUR PROVIDER)

Blue Cross Blue Shield Independent Health Univera Healthcare United Health Care Aetna CIGNA

ID #:_____ Group #:_____ Effective Date:_____

Prescriber Full Name (if not you):_____ DOB:_____

Address (if different from yours):_____

Phone # (if different from yours):_____ Social Security #:_____

Secondary Insurance Company Name:_____

Last Primary Care Physician/Group:_____

Why did you leave your last Primary Physician?_____

Do you see any specialists? Who?_____

Any recent hospitalizations/ER visits? Yes No When?_____

Where?_____Why?_____

Have you had your Annual Physical or Annual Wellness Visit (those over 65) this year? Yes No

Past Diagnoses_____

Do you take any Narcotic or Controlled Medications? Yes No If so, what one(s)?_____

Referred By:_____

By signing below, I grant Clifford Family Practice the ability to verify the information given above with NYS PMP (I-STOP) and the hospital records systems for Catholic Health (Soarian) and Kaleida Health (InfoClique). This information will only be used to verify my answers above and will be held to the same HIPAA standards as a current patient's. I understand that by submitting this form, I am not guaranteed to become a patient of Clifford Family Practice and that if I am not accepted as a patient, my information will be disposed of according to this office's HIPAA practices.

Signature:_____ Date:_____

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For Office Use:

Recvd:_____ 1st Atmpt:_____ 2nd Atmpt:_____ NYS PMP Check 0 A InfoClique 0 A Soarian 0 A