Neighborhood Health Center

NEW PATIENT REFERRAL FORM

Date/Time: _____ Request for Primary Care _____ Mental Health/Counseling _____

Desired Provider: _____ Previous Patient: Yes No

Patient name (last, first, middle initial): _____ Sex: M F other

Social Security Number: _____ Date of Birth: _____ Marital Status: S M D W

Ethnicity: Not Hispanic or Latino Hispanic or Latino Choose not to disclose

Race (circle all that apply): Asian American Indian Black/African American Native Hawaiian/Pacific Islander White More than one race Choose not to disclose

Address: _____ City: _____ State: _____Zip: _____

Phone Numbers: (H) _____ (C) _____ (W)_____

Last Primary Provider: _____ Referred by: _____

How did you hear about us? Friend/Family Radio Website Social-Media Another Provider Newspaper Office Sign

Employer Name: _____ Status: Full-time Part-time Retired None

Primary Insurance: _____ Secondary Insurance: _____

Student Status (if applicable): Full-time Part-time Name of College/Univ/School:_____

Medical Conditions:_____

_____

_____

Mental Health Only:

Presenting problem or reason for referral: _____

_____

Financially Responsible Parent or Guardian if under 18 years of age: _____

Social Security Number: _____ Date of Birth:_____