UB|MD PRIMARY CARE

Re-establishing Form

Patient Name: _____ **Date of Birth:** _____/_____/_____

Patient Phone Number: _____

Patient Address:

_____

MEDICATIONS: Please list the names of any medication you take, the dose, and the frequency (continue on back as needed).

1. _____
   Medication Dose Frequency
2. _____
   Medication Dose Frequency
3. _____
   Medication Dose Frequency

HOSPITALIZATIONS/SURGERIES: Please include type of surgery/illness, date and hospital.

1. _____
2. _____
3. _____

Have you seen another Primary Care provider since you were last in our office? If so, please list the provider below and provide your confirmation number for updating your insurance with UBMDPC as your PCP:

_____

PCP Change Confirmation Number: _____

INSURANCE:

Primary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID: _____ Group #: _____

Secondary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID: _____ Group #: _____