

**New Patient Application/ Fill out and return to WFM**

Woodfamilymedicine.com Phone 304-780-6958

PRINT Full Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ Leave Messages: Yes / No

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Previous Doctor: \_\_\_\_\_

Insurance: \_\_\_\_\_

\*Plan Type (circle one) : Self-Funded, Employer, State Issued

Employer: \_\_\_\_\_

Interested in Medical Marijuana: Yes \_\_\_\_\_ No \_\_\_\_\_

Interested in Weight Loss: Yes \_\_\_\_\_ No \_\_\_\_\_

List ALL Medical Problems You Have:

_____	_____
_____	_____
_____	_____

List the medications you have taken in the last six months (failure to do so may result in automatic discharge from WFM)

_____	_____
_____	_____
_____	_____

If you do not hear from WFM in 5 business days unfortunately you have not been selected as a patient. Thank you for your cooperation.

**Office use only below this line** \_\_\_\_\_

Approved: Yes / No Doctor Requests to speak to patient: Yes / No

Doctor Requests to Speak with Previous Doctor: Yes / No

Called: \_\_\_\_/\_\_\_\_/\_\_\_\_ Scheduled New Appt: \_\_\_\_/\_\_\_\_/\_\_\_\_