

# T. SCOTT WEBB, D.O.

## NEW PATIENT SCREENING

NAME: \_\_\_\_\_  
(FIRST) (MI) (LAST)

DOB: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

ADDRESS: \_\_\_\_\_ (APT) \_\_\_\_\_

CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_) \_\_\_\_\_

### INSURANCE

NO INSURANCE  
AMT DUE: \$ \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

### LIST ALL PRIOR PHYSICIANS SEEN IN PAST 5 YEARS

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### LIST ALL MEDICAL CONDITIONS/PROBLEMS/DIAGNOSIS

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### LIST ALL MEDICATIONS YOU TAKE (INCLUDING PAIN OR ANXIETY)

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REASON FOR NEEDING AN APPOINTMENT: \_\_\_\_\_

WERE YOU REFERRED TO DR. WEBB?  YES BY WHOM: \_\_\_\_\_  NO

DO YOU HAVE RELATIVES THAT SEE DR. WEBB?  YES WHOM: \_\_\_\_\_  NO

### FOR STAFF USE ONLY

SCHEDULE APPT:  YES  
 NO  
 AFTER RECORDS  
STAFF INITIALS: \_\_\_\_\_

MEDICAL RECORDS:  YES  NO

APPT DATE: \_\_\_\_\_

APPT TIME: \_\_\_\_\_

STAFF INITIALS: \_\_\_\_\_

PT WILL CALL TO MAKE APPT.