

NEW PATIENT Welcome SCREENING
Saluda Medical Center

Yes, we are accepting new patients! Let us get to know you to ensure that we can provide you with the best care possible.

Date _____

Potential Patient Name: _____

DOB: _____

Phone Number: _____

Do you plan to transfer care here? _____

Concern for which you would like to be seen: _____

Medications you take or need refilled: _____

Conditions you have been treated for in the past: _____

Last visit at previous provider: _____

Referred By: (how did you hear about us?) _____

Office Use Only: Screened by: _____ P C R Reviewed by: _____ Records requested Y N
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