

Alachua Health Services New Patient Information Form

Name: _____

Social Security Number: _____

Date of Birth: _____

Doctor: _____

Diagnosis: _____

Phones: _____

Address: _____

Insurance
information: _____

Past Medical
History _____

Medications _____

History of problem for which you are seeking
Therapy _____

Functional limitations and activities unable to do for which you would like
Therapy to improve_____

Note: all HIPA regulations and patient confidentiality will be honored
concerning the above information.

I agree to provide the following information for insurance authorization and
medical records of AHS llc

Sign_____ Date _____