MARSHALL
PRIMARY CARE

Jessica Sparks, M.D.

NEW PATIENT APPLICATION

Patient Name:______________________________ _____-_____-_______ ______

Last **First** **Middle Initial** **Date of Birth** **Age**

Mailing Address: ____________________ **City:** ____________ **Zip:** ______

Street Address: ____________________ **City:** ____________ **Zip:** ______

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Patient Employer:__________________ **Patient Occupation**__________________

□ Male □ Female Race: ____________ **□ Non Hispanic □ Hispanic Language:** ____________

Email Address: ____________________________________

Pharmacy:________________________**City:** ________________

Referred by:__________________ **Previous Primary Care Physician:** ____________

Primary Insurance Carrier: ______________________________

Insurance Identification Number: ______________________________

Secondary Insurance Carrier (if applicable): ________________________

Secondary Insurance Identification Number (if applicable): __________________

Current Medical Conditions:

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Current Medications: *(include prescription, non-prescription, over-the-counter, supplements, etc.)*

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Please complete this form and return to our office by fax, e-mail, mail or in-person.

Fax: 256.571.8502 Email: info@marshallprimarycare.com

Address: Marshall Primary Care, 7938 AL Hwy. 69 Suite 350, Guntersville, AL 35976