MGF MEDICINE

NEW PATIENT APPLICATION

NAME:_____ DOB:_____

ADDRESS:_____ PHONE:_____

INSURANCE NAME/CONTRACT #/GROUP #/POLICY HOLDER & DOB:

_____

***** IMPORTANT INFORMATION *****

- WE WILL NOT SCHEDULE AN APPOINTMENT WITHOUT KNOWING ALL MEDICATIONS THE PATIENT IS TAKING
- WE DO **NOT** ACCEPT MEDICAID
- **WE ARE NO LONGER PRESCRIBING CONTROLLED MEDICATIONS FOR NEW PATIENTS**

MEDICATIONS: LIST EACH MEDICINE AND THE DOSAGE

NAME	DOSAGE	HOW MANY A DAY

*****RETURN APPLICATION TO*****

MGF MEDICINE
100 TOWNCENTER BLVD.
SUITE 113
TUSCALOOSA, AL 35406

WE WILL CALL YOU WITH RESPONSE TO YOUR APPLICATION