Riverside Family Practice
PCP Intake Form

Name: _____ Date of birth:_____

Preferred e-mail: _____

For what condition(s) or symptom(s) are you wanting to see Dr. Meigs, our primary care provider?

Have you been referred to our clinic? Yes ____ No ____

If yes, who has referred you? _____

Do you require a referral by your insurance company? Yes ____ No ____

Do you have a family member that is seen at Riverside Family Practice? Yes ____ No ____

If yes, what is their name and relation to you? _____

If you will be using medical insurance to pay for your visits, what insurance do you have?

Insurance name: _____

Plan name: _____

Have you checked with your insurance to see if we are in-network?[1] Yes ____ No____

Thank you for providing the above information. We will reach out to you soon to complete the new patient registration process.

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[1] *You can find a list of plans we are in-network with on our website:* https://bloom-functional-medicine.com/insurance