



## **New Patient Forms**

Patient Name: First Middle In	-16-1					
Primary Patient Phone Number: (_						
Date of Birth://						
Social Security #:						
Community Name:						
Circle One: Independent Living	Assisted Living	Skilled Nursing				
Billing Address:						
City:	_ State: Ziŗ	o:				
Room #:	-					
<ul> <li>Please fax/email the following:</li> <li>Insurance Cards - Copies</li> <li>Power of Attorney- Healthcare and/or Financial</li> <li>Records from Most Recent Hospital Stay (if applicable)</li> </ul>						
By signing this form, I (or my designee) acknowledge and provide consent for Twin Cities Physicians to provide primary care services, including obtaining outside medical records for continuity of care. I acknowledge that I, or my designee, will promptly follow up with the Twin Cities Physicians team regarding any questions/concerns.						
Patient or POA Signature:						
When completed please send information to:						

www.mytcp.org

Fax: 763-312-1800 or Email: newadmit@mytcp.org





## **Patient Information Sheet**

Patient Name:			
First	Middle Initial	Last	
Emergency Contact / Po	ower of Attor	ney-Heal	Ithcare Information
Name	Pho	one: (	)
Relationship to Patient: _			
Previous Primary Care	<u>Provider</u>		
Provider Name/Clinic:			
Phone: ()	Fax: (	)	
Date of last visit with Prev	ious Primary (	Care Prov	rider:
Additional information you provider (optional):	u wish to share	e with you	ur new Twin Cities Physicians
<del></del>		· · · · · · · · · · · · · · · · · · ·	

Attention Community: Please update the patient's records to list Dr. Clemencia Rasquinha as the patient's





First

**Patient Name:** 

Primary Care	Provider			
Middle Initial	Last			

## Patient's Current Prescription Medications Medication & Dosage How often you take medication Patient's Current Over-the-Counter Medications/Vitamins Over-the-Counter Medication/Vitamin & Dosage How often you take the Over-the-Counter Medication/Vitamin





<b>Patient Name:</b>						
	First	Middle Initial	Last			
Known Allergies:						
Past & Present med	lical concerns, inc	luding any proc	edures or hos	spitalizations:		
				<del>, , , , , , , , , , , , , , , , , , , </del>		
Family Medical His	tory:					
Father						
Mother						
Siblings						
Children						
Social History:						
Marital Status: (Ci	rcle one)	Single	Married	Divorced	Widowed	
Occupation:						
Have you ever used Frequency of	I tobacco products of usage/Packs pe			_Quit Date (If a	applicable):	
Do you consume ar	ny alcohol: 🔲 Ye	es 🗌 No	Frequency: (0	Circle One) <b>D</b> a	aily Weekly	Monthly
Alcoholic di	rinks consumed in	one sitting: (Cir	cle one)   1   2	2   3   4   5-7	8-11   12-17   18-2	23   24-35   36+
Any other Drug Use	):					