TWIN CITIES PHYSICIANS
Onsite Primary Care

1415 Lilac Drive North, Suite 190 • Minneapolis, MN 55422
PHONE: 763-267-8701
FAX: 763-231-9602

# New Patient Forms

**Patient Name:** _____
First Middle Initial Last

**Primary Patient Phone Number: (_____)_____**

**Date of Birth: _____/_____/_____**

**Social Security #: _____ - _____ - _____**

**Community Name: _____**

**Circle One:** Independent Living Assisted Living Skilled Nursing

**Billing Address:_____**

**City: _____ State: _____ Zip: _____**

**Room #:_____**

## Please fax/email the following:

- **Insurance Cards - Copies**
- **Power of Attorney- Healthcare and/or Financial**
- **Records from Most Recent Hospital Stay** (if applicable)

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:**

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

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# Patient Information Sheet

**Patient Name:** _____
First Middle Initial Last

## Emergency Contact / Power of Attorney-Healthcare Information

**Name**_____ **Phone:** (_____)_____

**Relationship to Patient:** _____

## Previous Primary Care Provider

**Provider Name/Clinic:**_____

**Phone: (_____)_____** **Fax: (_____)_____**

**Date of last visit with Previous Primary Care Provider:**_____

**Additional information you wish to share with your new Twin Cities Physicians provider** (optional)**:**

_____
_____
_____
_____
_____
_____
_____
_____

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

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Primary Care Provider

**Patient Name:** _____
First 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

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**Patient Name:** _____
First Middle Initial Last

**Known Allergies:**

_____

_____

**Past & Present medical concerns, including any procedures or hospitalizations:**

_____

_____

_____

_____

_____

**Family Medical History:**

**Father**_____

**Mother**_____

**Siblings**_____

_____

_____

**Children**_____

_____

_____

**Social History:**

**Marital Status:** (Circle one) **Single** **Married** **Divorced** **Widowed**

**Occupation:**_____

**Have you ever used tobacco products:** ☐ **Yes** ☐ **No**

**Frequency of usage/Packs per day:** _____ **Quit Date** (If applicable): _____

**Do you consume any alcohol:** ☐ **Yes** ☐ **No** **Frequency:** (Circle One) **Daily** **Weekly** **Monthly**

**Alcoholic drinks consumed in one sitting:** (Circle one) | 1 | 2 | 3 | 4 | 5-7 | 8-11 | 12-17 | 18-23 | 24-35 | 36+ |

**Any other Drug Use:** _____

_____