Dr. Angela Pohl, D.O.
Dr. Caitlin Schmidt, DO

New Patient Registration

Anne Zwart, PA-C
Amanda Gross, PA-C
Rikki Getz, PA-C

Which TBIM Provider would you like to request? _____

Who referred you to TBIM? _____

Do you have a current PCP? If so, who? _____

(Name and Relationship to patient and/or practice)

Insurance Info – *we do not accept any form of Medicaid, United Healthcare/UMR, or Health Alliance Plan*

Primary: _____ **Subscriber #** _____ **Contract/Grp #** _____

Secondary: _____ **Subscriber #** _____ **Contract/Grp #** _____

Not disclosing the full truth may result in dismissal from practice; *please initial if you agree to these terms*: _____

**** Disability insurance payments are not an acceptable form of payment for services rendered at TBIM. We do not bill Disability Insurance companies. By initialing, you agree to the terms of this requirement: _____***

**** Please be aware the providers practice preventative medicine including national recognized standards of care testing. You will be scheduled yearly for a preventative health maintenance exam and at this time appropriate testing will be ordered. If you are on Medicare, you will be required to have an Annual Wellness Visit in addition to a Physical. Physicals are not covered by traditional Medicare. By initialing, you agree to the terms of this requirement: _____***

****TBIM has a very strict Controlled Substance Medication Policy. We require a urine drug screen for all new patients and require office visits at least every 90 days to review the effectiveness of these medications. In addition, we require patients to review & sign a full contract at least annually. By initialing, you agree to the terms of this requirement: _____***

New Patient Information:

Name *(Last, First, MI)* _____

Preferred Name: _____ **Gender:** _____

Address *(including zip code)* _____

Cell Phone _____ **Home Phone** _____

Date of Birth _____ **E-mail Address** _____

Reason for appointment? _____

_____

Prescribed Medications_____

_____

Patient Signature: _____ **Date:** _____

Once we receive this back completed, our Clinic Coordinator will call you to review & discuss scheduling.