

Appointments available Monday - Friday 9 AM- 5PM  
Telehealth visits available 7 days a week from 8 AM - 8 PM

### New Patient Application

Today's Date

First Name

Last Name

Phone Number (This is the number we will call and text to communicate with you)

EMAIL Address (This is the email that will be used to create your Patient Portal)

Date of Birth (MM/DD/YYYY)

What current Chronic Issues do you have? (Diabetes, High Blood Pressure, High Cholesterol, Anxiety/  
Depression, etc)

What current prescription medications do you take?

What past surgeries have you had?

What are your health goals?

Please upload the FRONT of your Driver's License. If the application is for a minor, upload one legal parent/  
guardian's Photo ID.

By submitting this application, I acknowledge that any false statements or deliberate omissions on this form  
may subject me to be terminated as a patient at Crossroads Medical Care