Redding Family Medical Group, Inc.

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New Patient Application

Patient's Name:_____

Address:_____

Patient's Date of Birth:_____ Male or Female?_____

Patient's Phone Number:_____

Insurance (please include a copy):_____

Current Medications:_____

_____

Surgeries:_____

_____

Current Health Concerns:_____

Provider you are requesting:_____

Please mail, fax or drop off completed form to:
Redding Family Medical Group
2510 Airpark Drive, Suite 201
Redding, CA 96001
Fax: (530) 244-1821
ALLOW 10 – 14 BUSINESS DAYS FOR PROCESSING