



REDDING
FAMILY MEDICAL GROUP, INC.

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