Child & Teen Medical Center
Love…Kindness..Excellence

New Patient Survey Form

Today's Date: _____ New Baby: ☐ No ☐ Yes- Hospital born at: _____

Patient Name: _____DOB: _____

Address: _____ City: _____ Zip_____

Name of Primary Insurance: _____ Through (circle) Employer/Private State

Name of Secondary Insurance: _____ Through (circle) Employer/Private State

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How did you hear about our clinic?

o Patient here in the past (returning to the clinic)
o Other siblings come to the clinic Sibling(s) Name(s):_____
o Ob-Gyn Clinic Clinic Name:_____
o Hospital (Name of Hospital) Hospital Name:_____
o Insurance Company
o Friend or Family referral (Name of Friend/Family) Name:_____ Child(ren)'s Name(s):_____
o Internet Search (Name)/Website (Name)/Facebook Website Name:_____
o Clinic Mailings/Advertisements/Drive By (Please circle)
o Other (please list)

Thank you for completing our survey!