



Thank you for considering Sierra Care Physicians and completing a Health Care Questionnaire. Sierra Care Physicians can only accept limited number of patients referred to us.

Please continue to look for medical care elsewhere as your Health Care Questionnaire is being reviewed. You will hear back from us within the next 30 days.

*We will call you to schedule you an appointment **only if we are able to accept you as a new patient.** Otherwise you will receive written notice.*

You may wish to contact Patient Services located on the back of most insurance cards to assist you in finding a medical provider.

Sincerely,

SIERRA CARE PHYSICIANS

Sierra Care Physicians

Litton Family Practice
140 Litton Dr. Suite 120
Grass Valley, CA 95945
Ph. (530) 272-9770
Fax (530) 272-9796

Penn Valley Family Practice
11400 Pleasant Valley Rd.
Penn Valley, CA 95946
Ph. (530) 432-7023
Fax (530) 432-7026

Health Care Questionnaire

Please complete this form and return it to our office. We will carefully review your information to determine if our office is well suited to caring for your health care needs. You will receive a response within 30 days after submitting the healthcare questionnaire form to Sierra Care Physicians. We encourage you to continue looking for a new medical provider during that time. Should you have any questions in completing this form please do not hesitate to contact our office.

*****PLEASE PRINT BELOW*****

Date: _____

Name: _____

First

Middle

Last

Address: _____

Street

City

Zip

Phone Number: _____ DOB: _____

Insurance: Primary _____ ID #: _____

Secondary _____ ID #: _____

Current Physician _____ Previous Physician _____

Reason for Transfer of care _____

Any family members currently in our practice (yes) (no) - If yes, who _____

Main conditions you would like us to help you with, in order of significance.

1.
2.
3.
4.
5.

Diagnosed Medical Problems.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Current Medications, Including Aspirin, Calcium, Vitamins, etc.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Additional Comments/Concerns

Note: This confidential record of your medical history will not be released to any person or persons without your written authorization to release your medical records.

By signing this I agree that all of the information is true and complete to best of my knowledge and understand that any missing or inaccurate information may lead to not becoming a new patient at the Sierra Care Physicians.

Signature: _____

Person requesting to become a new patient.

(Office use only)

Date Reviewed: _____ Reviewed by: _____

Admitted to practice ? (yes) (no)

Response Date: _____ By Phone call: _____

By: _____ By Mail: _____