



Redding Family Medical Group, Inc.

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New Patient Application

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Phone Number: _____

Current Medications: _____

Surgeries: _____

Current Health Concerns: _____

Provider you are requesting: _____

Please mail or drop off completed form to:

Redding Family Medical Group
2510 Airpark Drive, Suite 201
Redding, CA 96001

ALLOW 7 – 10 BUSINESS DAYS FOR A RESPONSE