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PH (906) 226-2233 ■ Fx (906) 226-2409

1504 SAND POINT RD., MUNISING, MI 49862
PH (906) 387-4220 ■ Fx (906) 387-5449

PRIMARY CARE APPLICATION / AGREEMENT

(Please note that completion of this form is not a guarantee of acceptance into the practice)

Name:		DOB:	Date:
Address:		Phone:	
Referred By:		E-Mail:	
Insurance Name:		Policy & Group#:	

The providers and staff of the Superior Walk-In and Family Health Center look forward to serving your primary care needs. As your primary care physicians it is our primary goal to prevent disease and promote wellness. We are committed to providing quality care and you, as a partner in the endeavor, are asked to agree to the following:

- Compliance with reasonable and standard of care health maintenance screening recommendations which may include vaccinations, cancer screenings including colon, breast and cervical cancer.
- Maintain regular health maintenance office visits of no less than annually for those without active medical problems and no less than twice a year for ongoing and active health issues.
- A desire for health through lifestyle improvement by striving to maintain a healthy body weight and eliminating health destroying habits such as excessive alcohol use and smoking.

Through this partnership we sincerely desire to promote both quality and quantity of life for you.

Your Superior Walk- In and Family Health Physicians,

Signature: _____

Health History (Chronic Conditions)

Current Medications (May Use Back of Paper)

Previous Physicians

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Pharmacy Used (For Release of Records)

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Please choose the Provider(s) you would like to see your application

<input type="checkbox"/> Kurt Olson, MD (Munising/Marquette)	<input type="checkbox"/> Christine Krueger, MD (Munising)	<input type="checkbox"/> Michelle Heslip, FNP (Marquette)
<input type="checkbox"/> Mark Olson, MD (Munising)	<input type="checkbox"/> Kellie Shipkey, NP-C (Marquette)	<input type="checkbox"/> Anthony Jurecic, NP-C (Marquette)

For office use only

<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Provider Signature & Date:
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