

PATIENT GROWTH

How to Get Your First Patients for a New Practice

Your first patients come from work you do 90 days before opening: an interest list, activated referrals, and local presence — not ads. The sequenced plan.



SCAN TO BOOK A CALL

Your first patients come from three sources, in this order: people who already know you (your network and community), people referred by professionals who trust you, and people who find your local presence (Google Business Profile, website, word of mouth). **The work that fills your opening month happens in the 90 days *before* you open — building an interest list and activating referral relationships — not in ads you buy after the doors are unlocked.** Paid acquisition is a later-stage tool. Here is the sequence, working backward from opening day.

Why "before the doors open" is the whole game

A practice that opens to an empty calendar starts its runway clock with zero revenue and maximum anxiety — and anxious pricing and scope decisions follow. A practice that opens with 30–50 committed or warm prospects starts with momentum, testimonials in week two, and word of mouth by month two.

The math makes the point. A direct primary care panel typically sustains at roughly 400–800 patients, filled over something like 6–18 months. The slope of that ramp is set early: founding members recruit the next cohort, because the dominant growth channel for membership practices is word of mouth and referral — concierge practices in particular grow by reputation. Your first 20 patients are not 3–5% of your panel; they're the seed crystal for the rest of it.

One gate before any of this: if you're still employed, **re-read your contract first**. Soliciting your current employer's patients can trigger contract and legal problems, and a non-compete may restrict where you can advertise and practice. Build your list from your community and network — not your employer's panel. [Physician Non-Compete Clauses, Explained](#)

Stand up a one-page interest site with email capture.

FROM THE BRIEF

T-minus 90 days: define the offer and start the list

1. **Write the one-sentence offer.** Who is the practice for, what do they get, what does it cost? "Membership primary care for families in [town]: same-day access, 30–60 minute visits, direct messaging with me, \$X/month." If you can't say it in a sentence, patients can't repeat it — and repetition is your marketing department.
2. **Set pricing now, not at launch.** Price to your cost structure and the value delivered, not to fear. Underpricing is one of the classic launch mistakes, and it's much harder to raise prices on founding members than to launch at the right number. [The Biggest Mistakes Doctors Make When Starting a Practice](#)
3. **Stand up a one-page interest site with email capture.** Not the full website — a single page: who it's for, what it includes, expected opening window, "join the founders list." Every conversation for the next 90 days ends with this link.
4. **Tell your personal network, individually.** Not a mass announcement — 50 to 100 personal messages to friends, former colleagues, neighbors, and community contacts: here's what I'm building, here's who it's for, who do you know? People who know you convert at rates no ad will ever match; your story is the asset.
5. **Start the founding-member framing.** A founders cohort (early access, locked pricing, direct input on the practice) gives people a reason to commit before you exist. Keep any founder discount shallow — the goal is commitment, not cheapness.

T-minus 60 days: build the referral engine and local presence

1. **List every professional who talks to your future patients.** For primary care and DPC: therapists, physical therapists, chiropractors, dentists, school nurses, personal trainers, small-business owners and HR contacts (employers are a meaningful DPC channel). For specialty cash-pay: the clinicians upstream of your service. Aim for 20–30 names.

2. **Have ten coffees.** Referral activation is personal, not postal. The ask is simple: "Here's who I help and how to send them to me; who should I be helping of yours?" A referrer needs three things — to understand the offer, to trust you, and to have a frictionless way to refer (a card, a link, a direct line to you).
3. **Claim and complete your Google Business Profile.** For a local clinic this single free listing typically outperforms early advertising: correct category, services, hours, photos, booking link. It's also where reviews will live, and reviews become your strongest conversion asset by month three.
4. **Publish the real website with online booking.** High-trust and simple: who you are, who it's for, pricing, how membership works, book a visit. Online booking matters — every "call to schedule" step loses people.
5. **Show up where your patients already gather.** One talk at a library, employer lunch-and-learn, school event, or community group per week beats any boosted post. You're a physician explaining how to navigate health care — that's useful content, and it's how a community learns you exist.

T-minus 30 days: convert the list

1. **Open enrollment to the founders list first.** Email the list: doors open [date], founding cohort is [N] spots, here's the link. Scarcity should be real — you really can only onboard so many people well in month one.
2. **Call the warm ones.** The 20 people who replied "tell me when you're ready"? Tell them personally. A ten-minute call enrolls a member; an email gets archived.
3. **Give local press and community channels the story.** "Local physician leaves hospital system to open membership practice" is a story local outlets and community newsletters actually run. The angle is access and the model, not you.
4. **Prepare the onboarding experience.** Intake forms, scheduling, payment, and a welcome that makes the first visit feel different from the 12-minute medicine they left. Your first 20 patients are about to become your sales force; what they experience is what they'll repeat.

Day 1 through 90: turn patients into the engine

1. **Deliver something repeatable-by-design.** Same-day access honored. Visits that run long. Messages answered. The model's promises, kept visibly — because the founding cohort's stories are the growth channel.
2. **Ask for the referral and the review, explicitly.** At the moment a patient expresses delight: "The practice grows by word of mouth — if you know someone who'd want this, here's how to send them." Most physicians never ask; patients almost always say yes.
3. **Keep working the referral list.** The professionals you met at T-60 need a touch every few weeks while trust builds. The first referral from each source is the slow one.
4. **Review the funnel monthly.** Where did each new patient come from? Double down on the two channels that actually produced, and drop the rest without guilt.

What people get wrong

The canonical error: treating patient acquisition as a post-launch task and a paid channel. Physicians budget for ads, open the doors, run the ads, and get silence — because a new practice with no reviews, no story in circulation, and no referral relationships has nothing for an ad to amplify. Your first patients come from your network, your community, and your story, not from paid acquisition; ads work later, as fuel on an engine that already turns. The second error is the inverse of underpricing: hiding the price. Membership practices that bury pricing force every prospect into a phone call most won't make. Put the number on the site.

For physicians transitioning an existing insurance panel to a membership model, the playbook differs in one big way: your current patients are your founders list, and the work is communicating the why and the how clearly and early — expect to keep your most engaged patients and lose some, which is normal and survivable. [How to Transition From Insurance-Based to Direct Primary Care](#)

Reality check

- **Demand is the real risk, and this is where you find out.** No launch task substitutes for the question: will enough people in your market pay for your care? If the interest list is silent at T-30, that's data — better learned before you resign than after. The reversible path (build the list and a small side panel while still employed, where your contract allows) exists for exactly this reason. [How to Test Your Own Practice Without Quitting Your Job](#)

- **The ramp is months, not weeks.** Even with a strong opening cohort, a sustaining panel commonly takes 6–18 months to fill. Plan personal runway of 6–12 months and judge months one through three by list growth and referral activity, not by panel size.
- **Word of mouth compounds slowly, then suddenly.** The first 90 days feel inefficient — coffees, talks, individual messages. This is the part that doesn't scale, and it's also the part that builds the only channel that does.
- **Some channels will fail.** A talk nobody attends, a referrer who never sends anyone, a press pitch ignored. Normal. You need two or three working channels, not ten.

Frequently asked

How do new medical practices get their first patients?

From people who already know the physician (network and community), professional referrals, and local presence — built in the 90 days before opening via an interest list, referral coffees, a Google Business Profile, and a simple website with booking. Paid ads are a later-stage tool, not a launch tool.

How long does it take to fill a patient panel?

For membership models like DPC, a sustaining panel of roughly 400–800 patients typically fills over 6–18 months. The opening cohort sets the slope, because referrals and word of mouth compound from those first members.

Should I advertise my new practice on Google or Facebook?

Not first. A new practice with no reviews and no word of mouth converts ads poorly. Claim your free Google Business Profile, build the founders list, and activate referrers; revisit paid channels once you have reviews and a working offer that ads can amplify.

Can I tell my current patients I'm leaving to start my own practice?

Carefully — soliciting your employer's patients can violate your contract, and non-solicitation language is common. Read your agreement and have ambiguous language reviewed before any patient communication. Building your list from your community and personal network is the safe lane.

What's a founding-member offer and do I need one?

A limited early cohort with locked pricing, early access, and direct input. It gives prospects a reason to commit before you open and seeds the word-of-mouth engine. Keep discounts shallow — underpricing founders sets a floor you'll fight later.

HOW OPENWELL CAN HELP

Done-for-you, end to end.

Openwell's done-for-you launch builds the machinery this 90-day plan runs on — the interest page, website with booking, Google profile, intake, and enrollment flow — so your pre-launch days go into conversations, not configuration.

Book a call → openwellhealth.com/book-a-call



SCAN TO BOOK

RELATED OPENWELL BRIEFS

- [How to Start Your Own Medical Practice From Scratch: The Complete Sequence](#)
- [Physician Non-Compete Clauses, Explained: What They Mean and Whether Yours Is Enforceable](#)
- [How to Test Your Own Practice Without Quitting Your Job](#)
- [How to Start a Direct Primary Care Practice](#)