Patient Intake Form

Date: _____

Patient Information

Full Name: _____
First (Legal) MI(Legal) Last

Address: _____ **City**:_____ **State**: _____ **Zip:** _____

Age: ____ **Birth Date**: _____ **Gender**: (circle) Female / Male **I am Under Age18** (circle) yes/ no

Social Security Number: _____-_____-_____ **Email Address**: _____

Home Phone: _____ **Work Phone**: _____**Cell Phone:** _____

Cell Phone Carrier: _____ **I prefer to receive calls at:** (circle) Home / Work / Cell

Marital Status (circle) Single/ Married/ Divorced/ Widowed/ Separated

Language: (circle) English / Spanish / Indian / Japanese / Chinese / Korean / Italian / French / Russian/ German/ Other

Race/Ethnicity: (circle) White/ American Indian/ Asian/ African American/ Hispanic or Latino/ Declined to answer

Employer: _____ **Occupation**: _____

Business Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse's Name: _____ **Spouse's Date of Birth**: _____

Emergency Contact: _____**Emergency Contact Phone Number:** _____

Who referred you to our office?_____**Primary Care Doctor**_____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records