PATIENT INTAKE FORM

(Clinic Use Only) MRN: _____ Date Received: _____

A. Personal Information

Full Legal Name: _____
Preferred Name/Nickname: _____
Date of Birth (MM/DD/YYYY): _____
Sex Assigned at Birth: _____
Gender Identity: _____
Pronouns: _____
Marital Status: _____

B. Contact Information

Street Address: _____
City, State, ZIP: _____
Mobile Phone: _____
Email: _____
Preferred Contact Method: _____

C. Insurance & Responsible Party

Primary Insurance Company: _____
Policy #: _____
Group #: _____
Name of Insured (if not patient): _____
Secondary Insurance: _____
Guarantor/Responsible for Payment: _____

D. Emergency Contact

Name: _____
Relationship: _____
Phone: _____
Alt. Phone: _____

E. Primary Care Provider

Physician/Clinic Name: _____
Phone: _____
Fax: _____

F. Reason for Today's Visit

Description of symptoms/concern: _____
Onset Date: _____
Severity: _____

G. Health Snapshot

Height (ft/in): _____
Weight (lb): _____
Allergies: _____
Current Medications: _____
Tobacco Use: _____
Alcohol Use: _____
Recreational Drug Use: _____
Past Major Illnesses / Surgeries: _____
Pregnant? (if applicable): _____

H. Consent & Acknowledgments