Excel For Freelancers Clinic
12345 Main St.
Anytown, CA USA
Phone: (555) 555-5555

E-mail Form

Print Form

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name: Lname1 | First Name: Name1 | Age: 0

Address:

City: | State: | Zip Code:

Email: | Referred by:

Home #: | Cell #: 5315 | Work #: | Ext.:

SSN #: | Date of Birth: | Driver's License #:

EMPLOYMENT INFORMATION

Employer:

Occupation:

Job Duties:

EMERGENCY CONTACT

Marital Status: Single

Spouse's Name: | Contact Number: | Contact Number:

Friend's Name: | Contact Number: | Contact Number:

INSURANCE INFORMATION

Insurance Carrier: | Insurance Plan: | Contact Number:

Group Number: | Policy Number:

Primary Care Physician: | Contact Number:

Address:

City: | State: AL | Zip Code:

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS

I hereby authorize the insurance carrier listed above to make payments directly to the Health care Provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the Health care Provider; otherwise I will be responsible for payment.

Last Name: Lname1 | First Name: Name1 | Date:

Patient Signature