



Excel For Freelancers Clinic

12345 Main St.
Anytown, CA USA
Phone: (555) 555-5555

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name	<input type="text"/>	First Name	<input type="text"/>	Age	<input type="text"/>
Address	<input type="text"/>				
City	<input type="text"/>	State	<input type="text"/>	Zip Code	<input type="text"/>
Email	<input type="text"/>		Referred by	<input type="text"/>	
Home #	<input type="text"/>	Cell #	<input type="text"/>	Work #	<input type="text"/>
				Ext.	<input type="text"/>
SSN #	<input type="text"/>	Date of Birth	<input type="text"/>	Driver's License #	<input type="text"/>

EMPLOYMENT INFORMATION

Employer	<input type="text"/>
Occupation	<input type="text"/>
Job Duties	<input type="text"/>

EMERGENCY CONTACT

Marital Status	<input type="text"/>		
Spouse's Name	<input type="text"/>	Contact Number	<input type="text"/>
		Contact Number	<input type="text"/>
Friend's Name	<input type="text"/>	Contact Number	<input type="text"/>
		Contact Number	<input type="text"/>

INSURANCE INFORMATION

Insurance Carrier	<input type="text"/>	Insurance Plan	<input type="text"/>	Contact Number	<input type="text"/>
Group Number	<input type="text"/>	Policy Number	<input type="text"/>		
Primary Care Physician	<input type="text"/>	Contact Number	<input type="text"/>		
Address	<input type="text"/>				
City	<input type="text"/>	State	<input type="text"/>	Zip Code	<input type="text"/>

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	<input type="text"/>	First Name	<input type="text"/>	Date	<input type="text"/>
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Patient Signature