

[company name] Patient Intake Form

Confidential - For Internal Use Only

Instructions

Please fill out all sections of this form completely and accurately. This information will help us provide the best care possible. All data is protected under HIPAA regulations.

Personal Information

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Insurance Information

Primary Insurance Provider: _____

Policy Number: _____

Group Number: _____

Insurance Phone Number: _____

Secondary Insurance Provider (if applicable): _____

Secondary Policy Number: _____

Medical History

Current or Past Medical Conditions: _____

Current Medications (include dosage): _____

Allergies (medications, food, environmental): _____

Past Surgeries (include dates): _____

Family Medical History (e.g., diabetes, heart disease): _____

Reason for Visit

Primary Reason for Visit: _____

Symptoms (include duration): _____

Consent and Acknowledgment

I certify that the information provided is accurate to the best of my knowledge. I authorize [company name] to use this information for treatment, payment, and healthcare operations as permitted under HIPAA.

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

[company name] | 123 Main Street, Anytown, IL 12345 | Phone: (555) 123-4567