Acme Medical Group
123 Main St
Any Town, NY 12345
(555) 123-4567

Patient Intake Form

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
John Sample		123-45-6789	05/15/1980	English	M

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY
789 Main st	Any Town, NY - 12345			

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE
555-567-8901	555-987-6543	john.s@email.com	Dr. Jane Doe	Anytown, NY 12345	Caucasian

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
Married	☐ Full-Time ☐ Part-Time	N	N	Janice Sample	(555) 246-8135	

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
Tech Solution Inc	
ADDRESS: 456 Business Ave	ADDRESS:
CITY, STATE ZIP: Anytown, NY 12345	CITY, STATE ZIP:
WORK PHONE: (555) 789-0123	WORK PHONE:

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
Apex Health Assurance	AHA123456789
NAME OF INSURED: John Sample	GROUP#: AH987654
ADDRESS OF INSURANCE COMPANY: 789 Insurance Blvd	COPAY AMT: $ 15
CITY, STATE ZIP: Insuranceville, NY 54321 — PHONE: (800) 555-1234	DEDUCTIBLE: $ 1000
RELATIONSHIP TO PATIENT: Self	EFFECTIVE DATE: 1/15/2024 — EXPIRATION DATE: 1/14/2025

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$
CITY, STATE ZIP — PHONE	DEDUCTIBLE: $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE — EXPIRATION DATE

I certify that I am the patient, or a duly authorized agent. I understand that, even though I have insurance I am responsible for payment today. I authorize release of medical information for insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. I authorize my insurance to assign benefits to Acme Medical Group (AMG). Under HIPAA Treatment, Payment Operations I give permission to AMG to access Pharmacy Benefit Managers for management of prescriptions.

SIGNATURE OF PATIENT/GUARDIAN

10/09/2024
DATE

Apex Health Assurance

Member Name
John Sample
Member ID
AHA123456789

Group No	**AH987654**
BIN	**246801**
Benefit Plan	**AHAPPO**
Effective Date	**01/15/2024**

Dependants
John Sample
Jane Sample
Jim Sample

Plan	**PPO**
Office Visit	**$15**
Specialist Visit	**$15**
Emergency	**$75**
Deductible	**$1000**

DATE: 10/9/2024

NAME: John Sample

AGE: 44

SEX: M

Dr. James Smith, M.D.

Endocrinologist

MBBS, MD | Medicine, MCPS

Specialist in Endocrinology

C/O neck swelling for past 2 weeks, no pain or discharge. No fever, night sweats, loss of appetite

P/E wt - 56 kg ht - 1.56 M

Vitals — normal

local exam - 10 cm swelling Rt m located in midline below thyroid notch

no tenderness or redness

moves freely.

G/E - no signs of hyper or hypo thyroid state

Tests - full thyroid profile

USG thyroid

Biopsy - needle

MD

Lic. # 123456

Days: Mon, Tue, Wed, Thu, Fri

Timings: 05:00 PM - 08:30 PM

123-456-7890, 444-666-8899

890 Main St, Any Town, NY 12345