Elite DNA Therapy Services
a comprehensive approach

Adult Intake Form

Demographics

Patient Name: _____ [ ] Male [ ] Female
Date of Birth: _____ Patient Social Security Number: _____
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Name (Person completing this form): _____ Relationship to Patient: _____
Home Address: _____ Primary Phone: _____
_____ Secondary Phone: _____

Doctor Information

Primary Physician: _____ Referring Physician: _____
Phone: _____ Phone: _____Specialty: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance Type: _____ Secondary Insurance Type: _____
Member ID Number: _____ Member ID Number: _____
Group Number: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's Social Security Number: _____ Policy Holder's Social Security Number: _____

Guardian Information (Complete If Applicable)

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____