

Patient Intake Form

Patient Information

Patient Name: _____ Sex ☐ M ☐ F Date: _____
Address: _____ City / State: _____ Zip: _____
Phone (Home): _____ Phone (Cell): _____
Email: _____ SSN: _____
Date of Birth: _____ Age: _____ Marital Status: ☐ M ☐ D ☐ S ☐ W
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Primary Care Physician: _____ Phone: _____
Contact Preference: ☐ Phone ☐ Text ☐ Email May we also contact you by mail? ☐ Yes ☐ No

Parent / Guardian / Spouse Information

Name: _____ Phone: _____
Address: _____ City / State: _____ Zip: _____
Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ Insured's Name: _____
Address: _____ City / State: _____ Zip: _____
Group Number: _____ Subscriber's Number: _____
Secondary Insurance: _____ Insured's Name: _____
Address: _____ City / State: _____ Zip: _____
Group Number: _____ Subscriber's Number: _____

Have you previously been seen at our practice? ☐ Yes ☐ No

When? _____ Reason? _____

How did you find out about us?

☐ Yellow Pages	☐ Internet	☐ Patient Referral: _____
☐ Advertisement	☐ Insurance	☐ Physician: _____
☐ Educational Seminar	☐ Employer	☐ Other: _____

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