# Georgia Osteopathic Care Center
# GA Campus PCOM

Patient Intake Form

Name: ______________________________ **Billing Address (if different)**

Address: ______________________________ ______________________________

______________________________ ______________________________

Phone: Home: ________________________Cell:__________________________

Email: ______________________________________________

Preferred method of contact: ________________________

OK to leave a message? Yes No

Personal: D.O.B. ____/____/_____ Race: ____________________

Language spoken: ________________________

Pharmacy: Name: __________________________Phone:__________________________

Emergency Contact Information:

Name: ____________________________ Phone: ______________________________

Relationship to Patient: _________________

If patient is a minor: Name of responsible Party: ____________________________

Relationship to child: ___________________________________

If the child is living with one Parent, is it ok to give information to the other parent? Yes or No

Parents Information: Father Name: ________________ D.O.B. _________

Mother Name: ________________ D.O.B. __________

Will you be submitting these charges to your insurance company? Yes or No

If Yes:

Insurance Information:

Name of Insurance: ____________________________________

Name of Policy Holder: ___________________

Policy Holder D.O.B.: ___________________

Group ID number: ___________________

Member ID number: ___________________

** This information is necessary to process any claims from your insurance company so that you can be reimbursed ***

How did you hear about us?

Magazine Billboard Referred by:______________________