GA-PCOM

Georgia Osteopathic Care Center

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

DOB ______ / ______ / __________ 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 / No

Parent's Information

Father's Name ______________________________ DOB ______ / ______ / ________

Mother's Name ____________________________ DOB ______ / ______ / ________

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

If yes - insurance information

Name of insurance ____

Name of policy holder ____

Policy holder DOB ______ / ______ / ___________

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?

____

____

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Referred by: ____