



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?

Referred by: _____