Patient Intake Form

New patient registration and health history. Please complete before your appointment.

ORGANIZATION

DATE

Patient registration

FULL LEGAL NAME

PREFERRED NAME

DATE OF BIRTH

SEX OR GENDER

PHONE

EMAIL

STREET ADDRESS

CITY AND STATE

ZIP CODE

PREFERRED LANGUAGE

PREFERRED PHARMACY AND LOCATION

EMERGENCY CONTACT

RELATIONSHIP

PHONE

Insurance and billing

PRIMARY INSURANCE

MEMBER ID

GROUP NUMBER

SECONDARY INSURANCE, IF ANY

MEMBER ID

GROUP NUMBER

WHO IS RESPONSIBLE FOR THE BILL?

- [ ] The patient
- [ ] A parent or guardian
- [ ] A spouse or partner
- [ ] Someone else

GUARANTOR NAME, IF NOT THE PATIENT

GUARANTOR PHONE

GUARANTOR DATE OF BIRTH

Reason for visit

WHAT BRINGS YOU IN TODAY?

PRIMARY CARE PROVIDER

REFERRED BY, IF ANYONE

Health history

Have you been told you have any of these?

- [ ] High blood pressure
- [ ] Heart disease
- [ ] Diabetes
- [ ] Asthma or COPD
- [ ] Thyroid condition
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Cancer
- [ ] Stroke
- [ ] Seizures
- [ ] Depression or anxiety
- [ ] Blood clots

SURGERIES AND HOSPITAL STAYS, WITH YEARS

CONDITIONS IN PARENTS, BROTHERS OR SISTERS (FOR EXAMPLE HEART DISEASE, DIABETES, CANCER)

TOBACCO OR VAPING

- [ ] Never
- [ ] Former
- [ ] Current

ALCOHOL

- [ ] None
- [ ] Occasionally
- [ ] Weekly
- [ ] Daily

COULD YOU BE PREGNANT?

- [ ] No
- [ ] Yes
- [ ] Not sure
- [ ] Not applicable

Medications and allergies

MEDICATION	DOSE	HOW OFTEN	PRESCRIBED BY

ALLERGIC TO	WHAT HAPPENED

Communication

PEOPLE ALLOWED TO HEAR ABOUT YOUR CARE: NAME AND RELATIONSHIP

CONTACT ME BY

- [ ] Phone call
- [ ] Voicemail with details
- [ ] Text message
- [ ] Email
- [ ] Patient portal

Consents

- [ ] I consent to examination and treatment by the providers at this practice
- [ ] I authorize the practice to bill my insurance and assign benefits to the practice
- [ ] I am responsible for charges my insurance does not pay
- [ ] I have received the practice notice of privacy practices
- [ ] The information on this form is complete and accurate

PATIENT OR GUARDIAN SIGNATURE

PRINT NAME

DATE