INTAKE FORM

PATIENT DEMOGRAPHICS			
LAST, FIRST NAME:		DATE OF BIRTH:	
GENDER: ☐ MALE ☐ FEMALE ☐ OTHER		SOCIAL SECURITY NUMBER:	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
MOBILE PHONE:	WORK PHONE:		EXT:
EMAIL:			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED		SPOUSES NAME:	
SPOUSES PHONE NUMBER:		ALT NUMBEER:	
EMERGEENCY CONTACT:		RELATIONSHIP:	
EMERGENCY CONTACT PHONE NUMBER:			
DO YOU HAVE INSURANCE? ☐ YES ☐ NO		POLICY HOLDER NAME:	
PRIMARY INSURANCE COMPANY:			
PRIMARY ID NUMBER:		PRIMARY GROUP NUMBER:	
SECONDARY INSURANCE? ☐ YES ☐ NO		POLICY HOLDER NAME:	
SECONDARY INSURANCE COMPANY:			
SECONDARY ID NUMBER:		SECONDARY GROUP NUMBER:	
PHARMACY NAME:			
PHARMACY ADDRESS:			
PHARMACY PHONE NUMBER:		PHARMACY FAX NUMBER:	
PRIMARY CARE PHYCISIAN NAME:			
PRIMARY PHONE NUMBER:		PRIMARY FAX NUMBER:	
HOW DID YOU FIND US? ☐ REFERRAL FROM PHYSICIAN ☐ WEBSITE		PHYSICIAN NAME:	
PATIENT SIGNATURE:			