PATIENT INTAKE FORM

PATIENT INFORMATION

Today's Date:_____/ / Name: _____
Last Name First Name Middle Initial

DOB:_____/_____/_____ Age:_____ Gender: ☐ M ☐ F Height:_____Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number:_____

Address: _____ _____ _____ _____
Street City State Zip Code

Home: (_____)_____Cell: (_____) _____

Work: (_____)_____Preferred Contact Number: Home ☐ Work ☐ Cell ☐

Email: _____

Emergency Contact:_____Emergency Phone: (_____) _____

Relationship to Patient: _____

Please list names of anyone you would like us to treat as your Personal Representative on your behalf. This person would have all the same rights to your medical record access that you do.

_____ _____
Name Relationship

_____ _____
Name Relationship

Preferred Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance Carrier

Insurance Carrier:_____

Carrier Phone: (_____)_____

Co-Pay Amount:_____

Policy Number:_____

Group Number:_____

Policy Holder's Name:_____

Policy Holder's DOB:_____/_____/_____

Policy Holder's SSN:_____

Effective Date:_____/_____/_____

Secondary Insurance Carrier (if applicable)

Insurance Carrier: _____

Carrier Phone: (_____) _____

Co-Pay Amount: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB:_____/_____/ _____

Policy Holder's SSN: _____

Effective Date:_____/_____/ _____

YOUR HEALTH

What are your main concerns for the visit today? Please list in priority from 1 to 4.

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS AND SUPPLEMENTS (That you're taking)	

ALLERGIES	
Medications/Supplements/Food/Environment:	**Reaction: (rash, nausea, shortness of breath, anaphylactic shock)**

ALCOHOL CONSUMPTION	TOBACCO CONSUMPTION
How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits* □ None □ 1-3 □ 4-6 □ 7-10 □ > 10	☐ Past Smoker ☐ Present Smoker How many years? _____ Packs per day: _____
Recreational Drug Use: ☐ Current ☐ Former ☐ Never ☐ Unknown	

REPRODUCTIVE HISTORY

Age of 1st Menses:_____

Date of Last Period:_____/_____/ _____

Date of Last Pap Smear:_____/_____/_____

Date of Last Mammogram:_____/_____/ _____

Date of Last Colonoscopy:_____/_____/_____

Date of Last Bone Density Scan:_____/_____/ _____

MEDICAL AND SURGICAL HISTORY

DIAGNOSIS	DATE OF ONSET OR RESOLUTION

SURGERIES	DATE

FAMILY HISTORY

Please list any conditions or illnesses (i.e., cancers, high blood pressure, diabetes, autoimmune diseases, heart disease, blood disease, asthma, depression, substance abuse, celiac disease, IBS).

Family Member	Diagnosis	Age at Onset	If Deceased, Age of Death
Mother			
Father			
Brother			
Sister			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			