Patient Intake Forms
Anthem Medical Care, PLLC

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____/_____/_____

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number**_____

Email_____ **Social Security Number**_____

Address Line 1_____**Address Line 2**_____

City_____**State**_____**Zip**_____

Marital Status_____ **Maiden Last Name**_____

Driver's License State_____ **Drivers License Number**_____

Demographics

Sexual Orientation

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity_____ **Language**_____

Emergency Contact

Relationship to Contact_____

Full Name _____
First Middle Last Suffix

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number**_____
Address Line 1_____**Address Line 2**_____

City_____**State**_____**Zip**_____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

**If you chose "Someone Else", Please fill out the following:*

Relationship to Contact_____

Full Name _____
First Middle Last Suffix

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number**_____

Method of Payment

What will be your method of payment? ◯ **Insurance** ◯ **Self-Pay**

**If You are not the primary policy holder, please fill out the following:*

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____/_____/_____

Policy ID Number_____ **Social Security Number**_____

PolicyHolder Address_____**Address Line 2** _____

City_____**State**_____**Zip**_____

**If you are unable to provide your insurance information, please provide a reason before continuing*

_____
_____
_____

Secondary Insurance Policy

**If you do not have a secondary insurance policy, you can leave this blank*

Insurance Company_____ **Policy Number**_____

Insurance Plan_____**Insurance Phone Number** _____

Group Number_____

Insurance Company Address_____**Address Line 2**_____

City_____**State**_____**Zip**_____

Relationship to Secondary PolicyHolder_____

**If you are not the secondary policyholder, please fill out the following:*

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____/_____/_____

Insurance ID Number_____**Social Security Number**_____

PolicyHolder Address_____**Address Line 2** _____

City_____**State**_____**Zip**_____

Additional Information

Please List your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

Please list all current medications

Medication	Medication Dosage	How often do you take medication?

How did you hear about us?

_____
_____
_____