



Patient Intake Form

Patient Name: _____ Date of Birth: ____/____/____

What would you like our staff to call you? _____

Address: _____
(Street) (City/State/Zip)

Home Phone: (____) ____-____ Cell Phone: (____) ____-____

E-Mail Address: _____

Sex Assigned at Birth: _____ Current Gender Identity: _____ Pronouns: _____

Employer Name: _____ Employer Phone: (____) ____-____

Primary Care Physician: _____
(Name)

How did you hear about our practice? _____

Person Responsible for Bill (If Different From Patient):

Guarantor Name: _____ Date of Birth: ____/____/____

Relationship to Patient (please check): () Parent () Spouse () Other: _____

Address: _____ Phone: (____) ____-____

Employer Name: _____ Employer Phone: (____) ____-____

Employer Address: _____
(Street) (City/State/Zip)

Emergency Contact:

Name: _____ Relationship: _____

Cell Phone: (____) ____-____ Work / Home Phone: (____) ____-____

Address: _____
(Street) (City/State/Zip)

A 24-HOUR CANCELLATION NOTICE IS REQUIRED. IF LESS THAN 24-HOUR NOTICE IS GIVEN, A MISSED APPOINTMENT FEE WILL BE ASSESSED.

ALL SALES FINAL ON SUPPLEMENTS.

Signature: _____ Date: _____