Patient Intake Form

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

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: ____________________