Patient Informa	ation		
Name			DOB (MM/DD/YYYY):
Gender:   Ma	le □ Female □ Other:	Preferred Pronouns: □ He/Him □ She/He	r □ They/Them □ Other:
Address:		,	City
State:	Zip:	Email:	<u>'</u>
Phone:	,	Preferred Contact Method: □ Phone □ Email □Text	
Emergency Contact Name:			Phone:
Relationship to	Patient		
Insurance Info	rmation (if applicable)		
Provider:		Policy number:	
Group Number:		Policyholder Name	
Relationship to	o Patient: □ Self □ Spo	use  Parent  Other:	
Reason for Vis	sit		
Primary Reaso	on for Visit:		
How long have you had this issue?		Have you been treated for this before? □ Yes □ No	
Medical Histor	y Summary		
-	ny of the following cond ke □ Other:		□ Hypertension □ Heart Disease □ Asthma □
Are you currently taking any medications? □ Yes □ No		If yes, list medications:	
Do you have any allergies? ☐ Yes ☐ No		If yes, list allergies:	
Have you had any surgeries or hospitalizations? □ Yes □ No		If yes, list procedures and dates:	
Lifestyle & Soc	cial History		
Do you smoke	or use tobacco produc	ts? □ Yes □ No □ Former Smoker	
Do you consur	me alcohol? □ Yes □ N	o □ Occasionally	
Do you use red	creational drugs?   Yes	s □ No	
Occupation:			
Do you have a	ny concerns about acc	ess to healthcare, transportation, or financia	al barriers? □ Yes □ No
If yes, please of	describe:		
Pharmacy Info	rmation		
Preferred Pharmacy Name: Phone Number:			
Address:			
Consent & Sig	nature		
I confirm that t	he information provided	is accurate to the best of my knowledge.	
Signature:			Date: