INTAKE FORM

PATIENT INFORMATION	☐New Patient ☐Existing Patient ☐New Equipment ☐ Updating	
Name:	**Gender:** ☐ Male ☐ Female	**Marital Status:** ☐S ☐M ☐ W ☐D
Mailing Address:	**Physical Address (if different from mailing):**	
City:	**State:**	**Zip:**
Phone:	**SSN:**	**DOB:**
Cell:	**Height:** ft in	**Weight:** lbs
Prescribing Physician:	**Primary Care Physician:**	
Emergency Contact/Representative:	**Relationship to patient:**	
Address:	**Phone:**	

INSURANCE INFORMATION ☐ Primary ☐ Secondary ☐ Other	INSURANCE INFORMATION ☐ Secondary ☐ Other
☐ Medicare ☐ Medicaid ☐ Other	☐ Medicare ☐ Medicaid ☐ Other
ID#:	**ID#:**
Ins Company:	**Ins Company:**
Primary Cardholder Name:	**Primary Cardholder Name:**
Primary Cardholder DOB: _____/_____/______	**Primary Cardholder DOB:** ____/_____/______

***Responsible Party:** ☐Self ☐ Parent ☐ Spouse ☐ Other

Name:___________________________________

Address:_________________________________

City/St/Zip: ______________________________

Phone:__________________________________

DOB: _____/______/________

SSN: _______/_____/__________

DL# ____________________ **St:** _____

If the patient is not over 18 years of age at the time of service, there must be a responsible party.

______________________________ ______________________________

Printed Name of Patient or Personal Representative **Signature of Patient or Personal Representative**

__________ ____________________ ______________________________

Date **Relationship to Patient (if not patient)** **Patient Being Represented**