NEW PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS

NAME		DATE OF BIRTH	SOCIAL SECURITY NUMBER	
SEX ❑ FEMALE ❑ MALE	HOME PHONE	CELL PHONE	E-MAIL ADDRESS	
PERMANENT STREET ADDRESS		CITY	STATE	ZIP CODE

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP ADDRESS/PHONE NUMBER
OCCUPATION	EMPLOYER
EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS		
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑ YES ❑ NO
FULL NAME CONTACT #2		ADDRESS		
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑ YES ❑ NO

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS				
POLICY NUMBER	GROUP/PLAN NUMBER			

Medical and Family History:

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety			Open Wounds/ Ulcers		
Arrhythmia (Irregular heartbeat)			Osteoarthritis		
Asthma			Osteoporosis		
Bleeding Problems			Peripheral Vascular Disease		
Blood Clots (DVT)			Pneumonia		
Cancer			Psychiatric Illness (Depression)		
Diabetes			Pulmonary Embolus		
Heart Attack			Reflex Sympathetic Dystrophy		
Heart Disease			Reflux		
High Blood Pressure			Rheumatoid Arthritis		
High Cholesterol			Seizures		
Infection			Stroke		
Kidney Disorders			Ulcers		
Lung Disease			Other:		

Medications:

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Allergies:

Aller gy	Reacti on
1.	
2.	
3.	
4.	
5.	

Surgical and Hospitalization History:

Previous Operation/Hospitalization	Year (approx.)	Any Complications?
1.		
2.		
3.		
4.		
5.		

Social History:

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

For Females Only: Do you think you may be pregnant at this time? Yes No

Signature of Patient or Legal Guardian

Date

Patient's Name