First and Last Name: _____Gender: _____ DOB: _____

Phone number: _____ Secondary Phone number: _____

Email: _____ Other contact info: _____

Address: _____ City, State _____

Does patient reside in a facility? Yes No If yes please name _____

Does patient have a power of attorney? Yes No If yes, please provide power of attorney paperwork.

Religious affiliation if any: _____

Emergency Contact Name _____ Phone Number _____

Medical History : ☐ Herpes ☐HIV/Aids ☐Thrush ☐Hepatitis ☐Cancer ☐Diabetes ☐ Smoker

Allergies: _____

Any medical condition within the past five years:

_____

Insurance: Please provide your insurance card to the front desk

Name: _____ DOB _____ SSN _____

Insurance Company _____ Member ID _____

By signing you verify that the above information is true and correct to the best of our knowledge.

X Signature _____ Date _____

DO NOT MARK BELOW THIS LINE: OFFICE USE ONLY

INSURANCE _____ ID NUMBER _____

MEDICAID ☐ MEDICARE ☐FFS ☐ELIGIBLE FOR MEDICARE
REFERRED ☐PREDETERMINATION ☐ PREAUTHORIZATION

NOTES: _____

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