New Patient Intake Form

Patient Name: ____ **Date of Birth:** ____________

Mailing Address: ________________________**City:** _______________ **State:** _____ **Zip:** _______

Phone Number: (HOME) ________________ (CELL) _________________

Email Address: ____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: _________ **Ethnicity:** ______________☐ I'd Rather Not Say **Preferred Language**: _______________

Profession: _________________________**Name of Employer:** __________________________________

Employer Address: ____

Employer Phone Number: ____________________________________

<u>Responsible Party Information (if different from above):</u>

Name: ____ **Date of Birth:** ____________

Mailing Address: ________________________**City:** _______________ **State:** _____ **Zip:** _______

Phone Number: (HOME) ________________ (CELL) _________________

Email Address: ___________________________ **Relationship to Patient:** ________________________

<u>Insurance Policy Holder Information:</u>

Primary

Insurance: _________________________ Subscriber ID: _____________ Group ID: __________________

Name as it appears on the card: __________________________________ Date of Birth: ______________

Relationship to patient: ____________________________

Secondary

Insurance: _________________________ Subscriber ID: _____________ Group ID: __________________

Name as it appears on the card: __________________________________ Date of Birth: ______________

Relationship to patient: ____________________________

<u>Pharmacy</u>

Preferred Pharmacy: ______________________________ **Telephone Number:** ____________________

Pharmacy Address: ____