Patient Intake Information

Date:_____

_____

(Legal) First Name (Legal) MI (Legal) Last Name DOB: Age:

Street:_____Apt #:_____

City:_____State:_____Zip:_____

Social Security #:_____Marital Status □S □M □D □W Spouse:_____

Preferred Language:_____

Race/Ethnicity: □White □American Indian or Alaska Native □Asian □Native Hawaiian/Other Pacific Islander

□Black or African American □Latino or Hispanic □Decline to Answer

Contact Info: Cell _____Home _____Work _____

Cell Carrier: □AT&T □ Boost Mobile □Metro PCS □Sprint □T-Mobile □Verizon Email:_____

Which Phone is your contact Preference: □Home □Cell □Work

Emergency Contact:_____Phone:_____

Who referred you to our office?_____

Occupation:_____Employer:_____

Employer Address:_____

Insurance Information: *A copy of your insurance card(s) will be made, in addition, please complete the information requested:*

Are you the policy holder? □Yes □No if no, who is? □Spouse □Parent □Employer other_____

_____

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security#:_____

Policy Holder's Employer:_____

Do you have a secondary insurance? □Yes □No if yes, please complete the following:

_____

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security#:_____

Policy Holder's Employer:_____

Patient History

Please give a brief description of the problem(s) you are experiencing:

_____

_____

_____

Is/Are the problem(s) getting better? Yes No or getting worse? When did the problems start?

_____

What appears to be the initial cause?_____

_____

Do you smoke?

_____Never _____Former Smoker

_____Current/Every Day Smoker _____Current/Some Days

Patient Signature: _____ Date: _____

Thank You!