"That's What We Do"

PATIENT INTAKE FORM

Patient Name: ____ DOB: ________________

SS# ________________________ Hm: ______________________ Cell:___________________

Address: ____ZIP+4___________Gender: M / F

Ethnicity: _________________________________Email Address: _______________________

Preferred Contact Method: Phone Text Mail Email

Preferred Reminder Method: Phone Text Preferred Language:______________

Parent/ Guardian Name:____________________________________ DOB: _______________

SS# ________________________ Relationship to Patient: _________________

Parent/ Guardian Name:____________________________________ DOB: _______________

SS# ________________________ Relationship to Patient: _________________

INSURANCE INFORMATION

Primary Insurance Name: _____________________________________(please furnish insurance card)

Policy Holder Name: _______________________________________ DOB: _______________

Address (if different from above) ____

Relationship to Patient: _____________________________________

Secondary Insurance Name: __________________________________(please furnish insurance card)

Policy Holder Name: _______________________________________ DOB: _______________

Address (if different from above) ____

Relationship to Patient: _____________________________________

Emergency Contact Name: __________________________________ Phone#: __________

Relationship to Patient: __________________________________