LOGO HERE	HEALTHCARE ORGANIZATION NAME ADDRESS

Patient Intake Form

Please fill in all the fields to the best of your knowledge so we can create an accurate health profile for you. This helps us to serve you better.

PATIENT INFORMATION		
FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	GENDER	EMAIL
CONTACT INFORMATION		
PHONE (HOME)	PHONE (CELL)	PHONE (WORK)
ADDRESS (STREET, APARTMENT, CITY, STATE, ZIP CODE)		
EMERGENCY CONTACT INFORMATION		
NAME	RELATIONSHIP	
PHONE (HOME)	PHONE (CELL)	PHONE (WORK)
INSURANCE INFORMATION		
PAYER NAME	PLAN NAME	MEMBER ID
GROUP NUMBER	RELATIONSHIP TO INSURED	SSN

ADD CONTACT INFORMATION HERE <PHONE, FAX, WEB, EMAIL ETC>

LOGO HERE	HEALTHCARE ORGANIZATION NAME ADDRESS

OTHER PROVIDERS		
PRIMARY CARE PHYSICIAN NAME	PHONE	PRACTICE NAME
REFERRING PHYSICIAN NAME	PHONE	PRACTICE NAME
REASON FOR VISIT		
CHIEF COMPLAINT (HISTORY OF COMPLAINT, SYMPTOMS, ETC)		
ALLERGIES		
MEDICATIONS (CURRENTLY TAKING, FREQUENCY, DOSAGE)		
PAST MEDICAL CONDITIONS		
PAST SURGERIES		

ADD CONTACT INFORMATION HERE <PHONE, FAX, WEB, EMAIL ETC>

LOGO HERE	HEALTHCARE ORGANIZATION NAME ADDRESS

SOCIAL HISTORY		
SMOKING START DATE	SMOKING END DATE	PACKS / DAY
ALCOHOL USE	FREQUENCY	GLASSES / DAY
DRUG USE	ILLICIT DRUGS	IV DRUGS
DRIVING		
CAFFEINE USE	FREQUENCY	CUPS / DAY
EXERCISE		
OCCUPATION		
FAMILY HISTORY		
MOTHER	FATHER	SISTER
BROTHER	DAUGHTER	SON

ADD CONTACT INFORMATION HERE <PHONE, FAX, WEB, EMAIL ETC>