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Patient Intake Form

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**Patient Information**

Full Name: _____ Date:_____
First MI Last

Address:_____ City:_____ State:_____ Zip:_____

Age:_____ Birth Date: ____/__/____ Check one: ☐Female ☐Male

Email Address:_____

Home Phone: (___)_____-_____ Work Phone: (___)_____-_____ Cell/Other: (___)_____-_____

I prefer to receive calls at (check one): ☐Home/☐Work/☐Cell

I am (check all that apply): ☐Under 18 ☐Single ☐Married ☐Divorce ☐Widow ☐Separated

Employer:_____ Occupation: _____

Business Address:_____ City:_____ State:_____ Zip:_____

Spouses Name:_____ Spouses Date of Birth: __/__/____

Emergency Contact Name: _____Emergency Contact Phone # (__)___-____

**Payment Information**

Person Responsible for Payment: _____

Social Security Number ___-___-____ Phone #: (___)___-____ Date of Birth: __/__/_____

**Insurance Information**

Do you have health insurance? (Click one): Yes ○ No ○

| Primary Insurance | Secondary Insurance |
|---|---|
| Insurance Company: | Insurance Company: |
| Policy Holder's Name: | Policy Holder's Name: |
| Relationship to Patient | Relationship to Patient: |
| Policy Holder's Birth Date: | Policy Holder's Birth Date: |
| Group Number: | Group Number: |
| Policy ID Number: | Policy ID Number: |
| Please have your insurance card and driver's license ready so they can be copied for the clinic's records. | |

Consent for Treatment:

*Assignment & Release – By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by singeing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*By signing below, I give my consent for examination and the performance for any tests or procedures needed. If patient is a minor, by signing I give consent for examination, test, and procedures for the above minor patient.*

Signed: _____ Date: _____

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