



New Patient Intake Form

Patient Name: _____ **DOB:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address (if different from mailing): _____

Home Phone: _____ **Cell:** _____

Can we send information via email? Yes No Email: _____

Do we have permission to leave messages on your answering machine or with others? Yes No

Contact Persons: If the person is someone, we can discuss medical information with please list.

Otherwise, we will NOT be able to discuss any information with them.

*** Authorization will only expire with written revocation from the patient. ***

Name: _____ **Phone # :** _____ **Relationship:** _____

Name: _____ **Phone # :** _____ **Relationship:** _____

Primary Care Physician/Provider: _____

Other Physician/Providers you would like to receive office notes:

Physician/Provider: _____ State: _____

Physician/Provider: _____ State: _____

Parent/Guardian #1 Name: _____ **Relationship:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address (if different from mailing): _____

Home Phone: _____ **Cell:** _____

Parent/Guardian #1 Name: _____ **Relationship:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address (if different from mailing): _____

Home Phone: _____ **Cell:** _____

Insurance- Primary: _____

Subscriber Name: _____ DOB: _____

Insurance- Secondary: _____

Subscriber Name: _____ DOB: _____

By signing below, you are authorizing and validating all the above information.

Patient Signature or Responsible Party: _____ **Date:** _____