PATIENT INTAKE FORM

Date: ____________________________________

Name: ____________________________________

Address: __________________________________

City, State, Zip: ____________________________

Home phone #: ______________________________

Cell #: ____________________________________

Date of birth: _______________________________

Social security #: ____________________________

Are you: ___single/divorced ___married/separated

For office use only

Patient ID: ________________

☐ Driver's License or photo ID

☐ Medical insurance card(s)

☐ No insurance

Employer name: ______________________________

Employer address: ____________________________

Employer city, state, zip: _______________________

Work phone #: _______________________________

Occupation: _________________________________

Medical insurance company: ____________________

Name of insured: ____________________________

Insured's date of birth: ________________________

How did you hear about this office?

____

Country of birth: ______________

E-mail: ______________________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________________ ____________________

Patient Name (please print) Date

____

Parent or Authorized Representative (if applicable)

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Signature