

DOCTOR NEW PATIENT INTAKE FORM

Patient Information:

Full Name: _____
Date of Birth: _____
Gender: _____
Social Security Number: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Phone Number: _____
Email Address: _____

Emergency Contact Information:

Full Name: _____
Relationship: _____
Phone Number: _____
Alternate Phone Number: _____

Insurance Information:

Primary Insurance Company: _____
Policy Number: _____
Group Number: _____
Policy Holder Name: _____
Relationship to Patient: _____
Insurance Company Phone Number: _____

Medical History (Please check all that apply):

- Diabetes
- Hypertension
- Heart Disease
- Asthma
- Allergies

Cancer

Seizures

Thyroid Problems

Arthritis

Bleeding Disorders

Hepatitis

HIV/AIDS

Mental Health Disorders

Other

Known Allergies:

Surgical History (Please list surgeries and dates):

Social History:

Do you smoke? (Yes/No): _____

Do you consume alcohol? (Yes/No): _____

Do you use recreational drugs? (Yes/No): _____

Occupation: _____

Marital Status: _____

Consent and Agreement:

I hereby authorize the attending physician and medical staff to perform diagnostic tests, treatments, and procedures deemed necessary. I acknowledge that no guarantees have been made as to the results of examinations or treatments. I understand that I am responsible for payment of all services rendered. I have provided accurate and complete information to the best of my knowledge.

Patient Signature: _____

Printed Name: _____

Date: _____

Physician/Provider Signature: _____

Printed Name: _____

Notice of Privacy Practices Acknowledgment:

I acknowledge that I have received and reviewed the Notice of Privacy Practices that explains how my medical information may be used and disclosed. I understand my rights regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Signature:

Date:

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