



New Patient Intake Forms

Please complete all applicable fields. Information is used for scheduling, care coordination, insurance verification, and patient communication.

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Gender		
			☐ M	☐ F ☐ Other	
Address		Apt #	City	State	Zip
Home Phone	Cell Phone	Email Address		SSN # (if required)	
Marital Status			Parent/Legal Guardian		
☐ Single	☐ Married	☐ Divorced	☐ Widowed		
Primary Doctor	Phone / City	Referring Doctor			
Referring Doctor Phone / City					
Referred By					
☐ Insurance	☐ Friend/Family	☐ Internet	☐ VA	☐ Hospital	☐ Other
Employer's Name	Occupation	Employer's Phone	Veteran?		
			☐ Yes ☐ No		



Emergency + Insurance

Please provide emergency contact and current insurance information used for scheduling, eligibility, verification, and care coordination.

EMERGENCY CONTACT

Name	Relationship	Home #	Cell #	Alternate #

INSURANCE INFORMATION

Policy Holder	SSN #	D.O.B.

Primary Insurance Company	Policy #	Group #

Secondary Insurance Company	Policy #	Group #



Demographics

Please complete demographic information used for reporting, communication preferences, and care coordination.

DEMOGRAPHIC INFORMATION

Race / Ethnicity

- | | | |
|-----------------------------------|---|--|
| ☐ Asian | ☐ White | ☐ American Indian / Alaska Native |
| ☐ Hispanic | ☐ African American | ☐ Other |

Language

- | | | |
|----------------------------------|----------------------------------|--------------------------------|
| ☐ English | ☐ Spanish | ☐ Other |
|----------------------------------|----------------------------------|--------------------------------|

Other language