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PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS

First Name: _____ Middle Initial: _____ Last Name: _____ Preferred Name: _____

Sex: _____ Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino

Race: ☐ Caucasian ☐ Black or African-American ☐ Asian
☐ American-Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Preferred Language: _____

CONTACT INFORMATION

Mobile Phone: _____ Home Phone: _____ Email: _____

Preferred Method of Communication: ☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Work Phone

Primary Home Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Secondary Home Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Work Telephone: _____

Primary Care Provider (PCP): _____ PCP Telephone: _____

Address: _____

NEXT OF KIN

Emergency Contact: _____ Relationship: _____

Contact Telephone: _____ Patient's Mother's Maiden Name: _____

Contact Home Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

INSURANCE

Primary Insurance Carrier: _____ Plan Name and Type: _____ Relation to Insured: _____

Policy Number: _____ Group Number: _____ Effective Date: ____/_____/____ Claim #_____

Secondary Insurance Carrier: _____ Plan Name and Type: _____ Relation to Insured: _____

Policy Number: _____ Group Number: _____ Effective Date: ____/_____/____ Claim #_____

Person Financially Responsible/Guarantor: _____ Relation to Patient: _____

Responsible Party Telephone #: _____ Responsible Party Social Security #: _____

Responsible Party Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____