# New Patient Intake Form

## Patient Information

| First Name | Last Name | Preferred Name | Patient Identifier (If known) |
|---|---|---|---|
| Gender | Preferred Pronouns | Date of Birth | Marital Status |

| Address | City | State | Zip Code |
|---|---|---|---|
| Email | Preferred Phone Number | | |

## Emergency Contact

| Full Name | Relationship | Contact Number |
|---|---|---|
| Full Name | Relationship | Contact Number |

## Health and Medical Information

| Primary Care Physician | Address | Contact Number |
|---|---|---|

Please list any medical conditions

Please list any current medication

## Insurance Information (If Applicable)

| Insurance Carrier | Insurance Plan | Contact Number |
|---|---|---|
| Policy Number | Group Number | Social Security Number |

## Employment Status

◯ Employed ◯ Self Employed ◯ Unemployed ◯ Other _____

| Occupation | Industry | Company Name |
|---|---|---|

| Company Address | City | State | Zip Code |
|---|---|---|---|

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

| Parent or Guardian Name (If Applicable) | Relationship to Patient (If Applicable) |
|---|---|
| Signature of Patient, Parent or Guardian | Date |