Patient Intake Form

Patient Information

Full Name:

DOB:

Gender:

Address:

City:

State:

Zip:

Phone:

Email:

Emergency Contact:

Contact Phone:

Insurance Information

Insurance:

Policy #:

Group #:

Subscriber:

Relationship:

Medical History

PCP:

Medications (Name / Dosage / Times / Adverse Effects)

Name	Dosage	Times	Adverse Effects

Patient Intake Form (continued)

Past Surgeries:

Past Medical History:

Family Medical History:

Symptoms (check all that apply)

- ☐ Fever
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Headache
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Rash
- ☐ Fatigue

Past Conditions (check all that apply)

- ☐ Hypertension
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Asthma/COPD
- ☐ Heart Disease
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Other

Acknowledgments

- ☐ HIPAA Privacy Practices
- ☐ Consent to treat/bill
- ☐ Assign insurance benefits

Consent and Signature

I authorize Family Health Primary Care to provide treatment, share medical info with insurance, and use my health info for care.

Signature: Date: