PATIENT’S INTAKE SHEET

Please fill out this form the best you can

DATE: Month: Date: Year:

Patient’s Name: Last, first, MI: ………………………………………………………
Patient”s Address:………………………………………
City: ……………………………….. State: .. Zipcode: ….. ….
Telephone:
Patient’s DOB: MM DD YY
Patient’s sex: M F
Patient’s relationship to insured: self spouse child other
Patient’s status: single: married: other:

Insurance Name:……………….
Insurance Address: ……………..
Insurance City …………… Insurance State: .. Zipcode: ….. ….

Insured’s name
Insured’s policy and group number:
insured’s DOB: MM DD YY insured’s sex M F
Insured’s address: …………………………….
Insureds Address:………………………………………
City: ……………………………….. State: .. Zipcode: ….. ….
Telephone:
Insured’s ID number:
Insured’s Policy Group or FECA number

Reason for visit:

Referring physician(if any):

Referring source(self, family, attorney etc.):

Pharmacy of choice:

Alternate pharmacy:

Laboratory of choice (if any)

Other healthcare providers or persons we shell send a report or medical record