Patient Intake

First Name:___________________________Last Name:______________________________MI:___

Female:_____Male:______Other:_________

Date of Birth: ___/___/___ Phone/home/cell:____

Mailing Adress:____________________________City/State/Zip:_____________________________

Physical Address:__________________________City/State/Zip:______________________________

Referring Physician/Facility:____

Emergency Contact:____________________________Phone:__________________________________

Employer:__________________________________Work phone:______________________________

Preferred method of appt. reminders: Text_______Email_______Voice Call__________________

Guarantor

Relationship to insured:Self_____Spouse_____Mother____Father_______Guardian__________

Guarantor/Parent/Guardian Name (Person responsible for bill):

First Name:_______________________(or self) Last Name:________________________MI:______

Date of birth:___/___/___ Phone/home/cell:____

Insurance Company:____

Group/ID #____

(please provide us with a front and back copy of your insurance card)