Medical Intake Form

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Samantha	Richards	Sam	
Gender	**Preferred Pronouns**	**Date of Birth**	**Marital Status**
Female	She/Her	09/22/1972	Divorced

Address	City	State	Zip Code
456 Example Street	New York	NY	123456

Email	Preferred Phone Number
samantharichards@123.com	123-456-789

Emergency Contact

Full Name	Relationship	Contact Number
Roger Richards	Father	000-000-000
Full Name	Relationship	Contact Number

Health and Medical Information

Primary Care Physician	Address	Contact Number
Dr Jacobs (Mercy Center)	68 East St	

Please list any medical conditions
Asthmatic

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
Financial Consultant	Finance	Smith and Smith

Company Address	City	State	Zip Code
456 West St	New York	NY	133480

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**
	11/18/2022