# Medical 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 medications | | |

| 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 |