New Client Intake Form

Client Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Dolores	Gray	Dolly	

Gender	Preferred Pronouns	Date of Birth	Marital Status
Female	She/Her	05/21/1976	Unmarried

Address	City	State	Zip Code
123 Example Street	Miami	FL	123-456

Email	Preferred Phone Number
dolores.gray@sample.com	123-000-123

Emergency Contact

Full Name	Relationship	Contact Number
Peter Gray	Brother	456-789-123
Full Name	Relationship	Contact Number

Health and Medical Information

Primary Care Physician	Address	Contact Number
Dr Lucy Smith	Central Medical Centre	000-999

Please list any medical conditions
Severe atopic dermatitis

Please list any current medication
Hydrocortosone

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
Baker	Hospitality	Dolly ' s Cakes

Company Address	City	State	Zip Code
456 Sample Street	Miami	FL	00000

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 Client, Parent or Guardian	Date
	10/11/2022