New Patient Intake Form

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)
Samantha	Carter	Sam	

Gender	Preferred Pronouns	Date of Birth	Marital Status
Female	She/Her	07/22/1989	Unmarried

Address	City	State	Zip Code
999 Example Avenue	New York	NY	000

Email	Preferred Phone Number
samantha.carter@123.com	000-111-222

Emergency Contact

Full Name	Relationship	Contact Number
Roger Carter	Father	999-111
Peter Carter	Brother	789-128

Health and Medical Information

Primary Care Physician	Address	Contact Number
Emily Peterson	55 Example Road NY	111-111

Please list any medical conditions
N/A

Please list any current medication
N/A

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Universal Health	A2	788-988
Policy Number	**Group Number**	**Social Security Number**
X3298	B	123456

Employment Status

☉ Employed ☐ Self Employed ☐ Unemployed ☐ Other _____

Occupation	Industry	Company Name
Software Developer	Information Technology	WebDesignersX

Company Address	City	State	Zip Code
6 Example Street	New York	NY	0021

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
	10/09/2022