New Patient Intake Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Address			
City			
State	**Zip code**		
Email address			
Social Security Number	**Driver's License Number**		
Home Phone	**Mobile Phone**		
Occupation			
Employer			
Business Address			
Spouse or Partner's Name	**Contact Number**		
Emergency Contact Name	**Emergency Contact Number**		
Primary Care Physician	**Physician Phone Number**		
Physician Address			
Should we contact this Physician in case of an emergency?		☐ Yes	☐ No
May we request your records from your primary care Physician?		☐ Yes	☐ No
Does your primary care Physician know you are seeking alternative health care?		☐ Yes	☐ No
What are the expectations of your visit today?			
What do we need to do for you to make this visit worthwhile?			
Who referred you to our office?			
Do you have insurance?		☐ Yes	☐ No
*** If so, please provide us with an insurance card so we can verify your coverage and benefits.**			

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that health and accident policies are an arrangement between an insurance carrier and myself, and that I am responsible for payment of my account.

Signature______________________________ Date____________________