Patient Intake Form
Integrated Physical Medicine, LLC

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City:_____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____ Race: _____ Preferred Language: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Cell Phone Provider: _____ (for text message reminders) Email Address: _____ (for IPM use only)

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employment Status: (circle) Employed/Unemployed/FT Student/PT Student/Retired Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Relationship: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your health insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Integrated Physical Medicine, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Integrated Physical Medicine, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____