

Today's Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_

PATIENT INFORMATION INTAKE FORM		
Legal Name:	Social Security #:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Other Name (Nickname):	Birth Date : ___ ___ / ___ ___ / ___ ___	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Partner
Address:	Home Phone: Mobile/cell Phone: Work Phone: E-mail:	May we contact you via e-mail or cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message at home with other residents? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave personal health information on your voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	Employer Address:	Primary Care Physician:  Phone #:
Name of Spouse:	Spouse Employer:	Spouse Employer Phone:
Landlord (if Renting):  Phone #:	How did you hear about us? <input type="checkbox"/> Triad Web-site <input type="checkbox"/> Physician Referral: _____ <input type="checkbox"/> Family/Friend: _____ <input type="checkbox"/> Other: _____	Reason for Visit:
Emergency Contact:  Relationship to patient:  Phone #:  Alternate phone #:	Nearest relative not living with you:  Relationship to Patient:  Phone #:  Alternative Phone #:	Is your visit due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No  Type of Injury: <input type="checkbox"/> Workers Comp      Injury Date: _____ <input type="checkbox"/> Auto Accident      Injury Date: _____ <input type="checkbox"/> Other                  Injury Date: _____
INSURANCE - POLICY HOLDER INFORMATION		
Name of Insured/Responsible Party:	Insured Social Security #:	Insured Date of Birth: ___ ___ / ___ ___ / ___ ___
Home Address  City, State, Zip:	Phone #:  Work Phone #:  Alternate phone/cell #:	Employer Name & Address:
Insurance Company:	Insured ID#:	Relationship to Patient:  Do you have secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No

*I have completed and reviewed the above information and to the best of my knowledge it is accurate. I authorize the individual physicians to advise me of any necessary procedures, diagnostic studies and treatment. I will notify you of any changes in my status of the above information*

Patient Signature: \_\_\_\_\_  
Patient or Parental Signature (parental signature if patient is a minor)

Date: \_\_\_\_\_