Patient Intake Form

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Patient Information

Full Name _____

Date of Birth _____

Gender _____

Address _____

Phone Number / Email _____

Emergency Contact _____

Insurance Information

Provider _____

Policy Number _____

Group Number _____

Responsible Party _____

Medical History

Past Illnesses & Surgeries _____

Allergies _____

Family Medical History _____

Current Medications

Prescription Drugs _____

Over-the-Counter Medications _____

Supplements _____

Consent & Authorization

HIPAA Acknowledgment _____

Consent for Treatment _____

Signature & Date _____

Practitioner Name: _____

Clinic Address: _____

Contact Number / Fax / Email: _____

Signature: _____

Date: _____