Medical Practice New Patient Intake Form

Please complete all sections of this form clearly. This information is confidential and will be part of your medical record.

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1. Patient Information

First Name:		Middle Name:		Last Name:	
Date of Birth (MM/DD/YYYY):		Gender:		Social Security Number:	
Street Address:					
City:		State:		Zip Code:	
Home Phone:		Cell Phone:		Email Address:	
Occupation:		Employer:			

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2. Emergency Contact Information

Full Name:		Relationship to Patient:	
Primary Phone:		Secondary Phone:	

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3. Health Insurance Information

Insurance Provider:		Policy Holder Name:	
Policy Holder DOB:		Relationship to Patient:	
Policy ID / Member ID:		Group Number:	

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4. Medical History & Current Health

Primary Care Physician Name/Clinic:	
Reason for Visit Today:	
Known Allergies (e.g., Medications, Food):	
Current Medications and Dosages:	
Past Surgeries or Hospitalizations (with dates):	

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5. Acknowledgment & Signature

I certify that the information provided above is true and accurate to the best of my knowledge.

Patient / Guardian Signature (Sign after printing):		Date (MM/DD/YYYY):	