NEW PATIENT INTAKE FORM

◯ **PRIMARY CARE** ◯ **PHYSICAL THERAPY** ◯ **MASSAGE THERAPY**

PATIENT NAME: _____ **PREFERRED NAME**: _____

DATE OF BIRTH: _____ **GENDER:** ◯ **MALE** ◯ **FEMALE**

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE: _____ IS IT OKAY TO LEAVE A DETAILED MESSAGE? ◯ **YES** ◯ **NO**

EMAIL: _____ MAY WE EMAIL YOU? ◯ **YES** ◯ **NO**

*PLEASE NOTE: EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION.

ARE YOU SET UP FOR THE PATIENT PORTAL? THIS IS AN IMPORTANT TOOL FOR COMMUNICATION WITH US, AND WE HIGHLY RECOMMEND USING IT TO STAY CONNECTED AND ACCESS YOUR INFORMATION EFFICIENTLY.

PARENT OR GUARDIAN (IF UNDER 18)

NAME: _____

RELATIONSHIP: _____ PHONE: _____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE

PRIMARY INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

POLICY HOLDER NAME: _____

SECONDARY INSURANCE COMPANY: _____

POLICY#: _____ GROUP#: _____

POLICY HOLDER NAME: _____

PREFERRED PHARMACY

NAME: _____ LOCATION: _____

REFERRING PROVIDER

NAME: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US?

◯ **FAMILY OR FRIEND** ◯ **PC MEMBER** ◯ **ONLINE** ◯ **PHYSICIAN** ◯ **OTHER:** _____