**Patient Intake Information**

Date: _____

_____ _____ _____ _____ _____

(Legal) First Name (Legal) MI (Legal) Last Name DOB: Age:

Street:_____Apt #: _____

City:_____State:_____Zip:_____

Social Security #: _____Marital Status S___ M___ D___W___Spouse:_____

Preferred Language: _____

Race/Ethnicity: White__ American Indian or Alaska Native __ Asian ___ Native Hawaiian/Other Pacific Islander __ Black or African American __ Latino or Hispanic __ Decline to Answer __

Contact Info: Cell Ph ___-___-____ Home Ph___-___-____ Work Ph___-___-____

Cell Carrier: _____Email: _____

Emergency Contact:_____Phone: ___-___-____

Who referred you to our office? _____

Occupation: _____Employer: _____

Employer Address: _____

Insurance Information: *A copy of your insurance card(s) will be made, in addition, please complete the information requested:*

Are you the policy holder? Yes____ No___ If no, who is? Spouse___ Parent___ Employer___ Other _____

_____ _____ _____ _____

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security#: _____

Policy Holder's Employer: _____

Do you have a secondary insurance? Yes___ No___ If yes, please complete the following:

_____ _____ _____ _____

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security#:_____

Policy Holder's Employer: _____

**Patient History**

Please give a brief description of the problem(s) you are experiencing:

_____
_____
_____

Is/Are the problem(s) getting better? Yes___ No___

When did the problem(s) start? _____

What appears to be the initial cause? _____

_____
_____

Do you smoke? Never☐ Former Smoker ☐Current/Everyday Smoker☐Current/Some Days☐

**Thank You!**