

NEW PATIENT INTAKE FORM

Practice name: [Practice name]

Address: [Practice address]

Phone: [Practice phone] **Email:** [Practice email]

Please fill in this form before your first visit. If a question doesn't apply to you, write "N/A". We use the information on this form for your treatment, for payment and for running the practice, as described in our Notice of Privacy Practices (if the practice issues one), and in other ways only as the law allows or requires.

1. Patient information

Full legal name: [First, middle, last]

Preferred name: [Preferred name]

Date of birth: [date]

Address: [Street, city, state, ZIP]

Mobile phone: [phone] Other phone: [phone]

Email: [email]

Preferred way to contact you:

☐ Mobile call ☐ Text message ☐ Email ☐ Other: [describe]

May we leave a detailed voicemail about your appointments? ☐ Yes ☐ No

If the patient is a minor or has a legal representative:

Parent, guardian or representative name: [full name]

Relationship to patient: [relationship]

Phone: [phone]

2. Emergency contact

Name: [full name]

Relationship: [relationship]

Phone: [phone]

3. Reason for your visit

Who referred you to us? ☐ Physician: [name] ☐ Friend or family ☐ Online search ☐ Other: [describe]

In your own words, what brings you in today?

[Describe the problem or goal]

When did it start? [date or approximate time]

What makes it better? [describe]

What makes it worse? [describe]

Rate your current pain or discomfort (0 = none, 10 = worst imaginable): [0 to 10]

4. Insurance or payment

☐ I will use insurance ☐ I will pay myself (self-pay)

If using insurance:

Insurance company: [carrier name]

Member ID: [ID number]

Group number: [group number]

Policyholder name: [full name]

Policyholder date of birth: [date]

Relationship to patient: ☐ Self ☐ Spouse or partner ☐ Parent ☐ Other: [describe]

5. Assignment of benefits and authorization to bill insurance (optional)

Practice: keep this section only if you bill insurance on the patient's behalf. Delete it if you are self-pay only.

☐ I authorize [practice name] to submit claims to my insurance company for services I receive, and to release to my insurer the information it needs to process those claims.

☐ I assign to [practice name] the insurance benefits otherwise payable to me for those services, so my insurer can pay the practice directly.

I understand that I remain responsible for any amount my insurer does not pay, as described in the practice policies below. This authorization stays in effect until I cancel it in writing, and cancelling it does not affect claims already sent.

6. Health history

Primary care provider: [name and phone]

Current medications and supplements (name and dose):

[List, or write "None"]

Allergies (medications, latex, oils, foods or other):

[List, or write "None known"]

Surgeries or hospital stays, with approximate dates:

[List, or write "None"]

Please check any that apply now or in the past:

- ☐ High or low blood pressure
- ☐ Heart condition or pacemaker
- ☐ Blood clots
- ☐ Diabetes
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Recent fracture, sprain or injury
- ☐ Joint replacement or metal implants
- ☐ Cancer
- ☐ Pregnancy (current)
- ☐ Skin condition or open wounds
- ☐ Numbness or tingling
- ☐ Other: [describe]

Is there anything else you'd like us to know about your health or your comfort during treatment?
[Describe]

7. Practice policies

Appointments and cancellations. Please give us at least [number] hours' notice if you need to cancel or reschedule. Late cancellations or missed appointments may be charged [\$ amount or policy].

Payment. Payment for your share of the cost is due [at the time of service / other terms]. If we bill your insurance, you remain responsible for any amount your insurer doesn't pay, including copays, deductibles and non-covered services.

Communication. We may contact you by the method you chose in Section 1 to confirm, remind you about or reschedule appointments.

Changes to your information. Please tell us if your contact details, insurance, medications or health change.

☐ I have read and agree to the practice policies above.

8. Acknowledgment of privacy notice

☐ I received a copy of this practice's Notice of Privacy Practices, or was offered one.

☐ This practice has told me it does not issue a Notice of Privacy Practices. (Leave for the practice to complete if this applies.)

9. Consent to evaluation

I agree to an initial evaluation by [practice name] and its providers. I understand I may ask questions at any time and may stop the evaluation or any treatment whenever I choose. Any specific treatment or procedure will be explained to me, and I may be asked to sign a separate consent for it.

10. Accuracy of information

I confirm that the information on this form is true and complete to the best of my knowledge. I will tell the practice if anything changes.

I agree this form may be signed electronically, and an electronic signature has the same effect as a handwritten one.

Signatures

Patient

Signature: _____

Name: [full name]

Date: [date]

Parent or Guardian (if the patient is a minor)

Signature: _____

Name: [full name]

Date: [date]

If a legal representative other than a parent or guardian is signing for the patient, write their name and relationship here: [full name and relationship]

For office use only: Reviewed by [staff name] on [date].