Patient Intake Form

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Practice name / logo: _____ Date: _____

1. Patient demographics

Legal last name _____ **Legal first name** _____

Middle name / initial _____ **Preferred name** _____

Date of birth (MM/DD/YYYY) _____ **Sex / gender identity** _____

Street address _____ **City** _____

State _____ **ZIP / postal code** _____

Primary phone _____ **Email** _____

Preferred contact method _____ **Preferred language** _____

■ I consent to receive appointment reminders by phone / text / email (circle applicable)

2. Insurance / subscriber information

Primary insurance (if self-pay, write “self-pay” and skip remaining insurance fields).

Insurance plan / payer name _____ **Member / subscriber ID** _____

Group number _____ **Plan type (HMO / PPO / other)** _____

Subscriber name (if not patient) _____ **Subscriber date of birth** _____

Patient relationship to subscriber _____ **Insurance phone (on card)** _____

Secondary insurance (if any)

Secondary payer name _____ **Secondary member ID** _____

Secondary group number _____ **Relationship to subscriber** _____

3. Reason for visit

Today’s chief concern / reason _____ **How long has this been present?** _____

Referring clinician (if any) _____ **Preferred pharmacy (see §6)** _____

Additional details:

_____

_____

4. Medical & medication history

List significant past medical conditions, surgeries, and hospitalisations. Attach extra pages if needed.

_____
_____
_____

Current medications (name, dose, frequency — include over-the-counter and supplements):

_____
_____
_____

5. Allergies

Medication allergies (or "none known") **Reaction type** _____

_____

Other allergies (food, latex, etc.) **Reaction type** _____

_____

6. Preferred pharmacy

Pharmacy name _____ **Pharmacy phone** _____

Pharmacy address / cross-streets **Mail-order pharmacy (if any)**

_____ _____

7. Emergency contact

Contact full name _____ **Relationship to patient**

_____

Primary phone _____ **Alternate phone** _____

8. HIPAA Notice of Privacy Practices — acknowledgment of receipt

Covered providers must make a good-faith effort to obtain a written acknowledgment that the patient received the Notice of Privacy Practices (45 CFR 164.520(c)(2)). This line is a template placeholder — confirm exact language with your privacy officer.

I acknowledge that I have received (or been offered) a copy of this practice's Notice of Privacy Practices.

Patient / authorised representative signature: _____ Date: _____

If signed by representative, print name and relationship: _____

■ Patient declined to sign acknowledgment — staff reason noted: _____

9. Consent to treat

Consent-to-treat language is practice- and state-specific. Replace this placeholder with language your compliance team has approved. This template does not give legal advice about any specific document.

I consent to evaluation and treatment by the clinicians of this practice for the conditions presented. I understand that I may ask questions and may refuse any recommended service.

Patient / authorised representative signature: _____ Date: _____

If signed by representative, print name and relationship: _____

10. Financial responsibility / assignment of benefits

Financial-responsibility and assignment-of-benefits wording varies by payer contract and state law. Confirm with your billing lead. For Medicare non-covered services, separate Advance Beneficiary Notice (ABN) rules may apply — see CMS ABN guidance; do not treat this line as an ABN.

I understand I am financially responsible for charges not paid by insurance (including deductibles, coinsurance, copayments, and non-covered services). I authorise this practice to bill my insurer and to receive payment of benefits on my behalf for services rendered.

Patient / authorised representative signature: _____ Date: _____