New Patient Intake Form

Welcome to our practice. Please complete this form using a blue or black pen. Fill the checkboxes completely and write clearly so we can read your answers.

Personal details

Full name

Date of birth

D D / M M / Y Y Y Y

Home address

Phone number

Email address

Gender *(Please cross one)*

- ◯ Male
- ◯ Female
- ◯ Prefer not to say
- ◯ Other

Insurance

Insurance provider

Policy or member number

Medical history

Do you have or have you had any of the following?

	Please cross one in each line Yes	No
High blood pressure	◯	◯
Diabetes	◯	◯
Heart disease	◯	◯

To respond ⊗ or ●

DRFT 0001

Please cross one in each line *Yes* *No*

Asthma ○ ○
Allergies ○ ○
Anxiety or depression ○ ○

Please list any current medications

Please list any allergies

Emergency contact

Contact name

Relationship

Contact phone

Consent and signature

I confirm that the information above is accurate and complete to the best of my knowledge. **Patient signature**

Date

D D / M M / Y Y Y Y

To respond ⊗ *or* ●