

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

		/			/				
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

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

☐ ☐

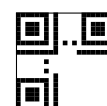
Diabetes

☐ ☐

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

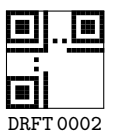
Consent and signature

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

Date

		/			/				
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

To respond ☒ or ☐



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