PATIENT INTAKE FORM TEMPLATE

DATE OF VISIT	ADMINISTRATOR

FIRST-TIME PATIENT?	REFERRED BY

PATIENT INFORMATION

FULL NAME		HOME ADDRESS	
PRIMARY PHONE NUMBER			
SECONDARY PHONE NUMBER			
EMAIL ADDRESS		WORK ADDRESS	
SOCIAL SECURITY NUMBER			
DATE OF BIRTH			

HEALTH CONCERNS / SYMPTOMS

Describe the reason for your visit.

When did your symptoms or illness begin?

What are your health goals for today's visit?

INSURANCE INFORMATION

INSURANCE CARRIER NAME		INSURED'S DATE OF BIRTH	
NAME OF INSURED		GROUP NUMBER	
SUBSCRIBER ID		PATIENT'S SIGNATURE	

EMERGENCY CONTACT INFORMATION

FULL NAME		RELATIONSHIP	
HOME PHONE		CELL PHONE	
WORK PHONE		EMAIL ADDRESS	

REFERRALS AND ADJUNCTIVE CARE

ARE YOU CURRENTLY UNDERGOING ANY OTHER MEDICAL TREATMENTS?

	Yes
	No

IF YES, PLEASE DESCRIBE THE REASON(S):

PRIMARY CARE PHYSICIAN	
PHONE NUMBER	
OFFICE ADDRESS	

PAYMENT INFORMATION

PAYEE		DATE OF PAYMENT	
RECEIPT NUMBER		AMOUNT PAID	
PAYMENT METHOD			
RECEIVED FROM		**RECEIVED BY**	

ACCOUNT DETAILS			**PAYMENT PERIOD**	
ACCOUNT BALANCE	PAYMENT MADE	BALANCE DUE	FROM	
			THROUGH	
DESCRIPTION OF SERVICES			ADDITIONAL PAYMENT NOTES	

ADDITIONAL NOTES

Any articles, templates, or information provided by Smartsheet on the website are for reference only. While we strive to keep the information up to date and correct, we make no representations or warranties of any kind, express or implied, about the completeness, accuracy, reliability, suitability, or availability with respect to the website or the information, articles, templates, or related graphics contained on the website. Any reliance you place on such information is therefore strictly at your own risk.