New Patient Intake Form Primary Care

Please fill out the following information to help us provide the best care possible.

Personal Information

- **Full Name: _____**
- **Date of Birth: _____ / _____ / _____ Age: _____**
- **Address: _____**
  City: _____ State: _____ ZIP: _____
- **Phone Number: _____**
- **Email Address: _____**
- **Emergency Contact Name: _____**
  Emergency Contact Phone: _____

Insurance Information

- **Insurance Provider: _____**
- **Policy Number: _____**
- **Group Number: _____**
- **Primary Policy Holder Name: _____**
- **Relationship to Policy Holder: _____**

Medical History

Please check if you have experienced any of the following:

[ ] Diabetes

[ ] High Blood Pressure

[ ] Heart Disease

[ ] Asthma

[ ] Allergies (Specify): _____

[ ] Other: _____

Current Medications

Medication Name	Dosage	Frequency	Reason for Taking

Acknowledgment

I confirm that the information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____