Patient Intake Form

Patient Information

Name: Emily Carter

DOB (MM/DD/YYYY): 07/22/1992

Gender: Female

Preferred Pronouns: She/Her

Address: 456 Oak Avenue

City: Denver

State: CO

Zip: 80203

Phone: (555) 678-9012

Email: emily.carter@email.com

Preferred Contact Method: Email

Emergency Contact Name: Michael Carter

Phone: (555) 234-5678

Relationship to Patient: Brother

Insurance Information (if applicable)

Provider: XYZ Health Plan

Policy Number: 987654321

Group Number: 54321

Policyholder Name: Emily Carter

Relationship to Patient: Self

Reason for Visit

Primary Reason for Visit: Severe migraines

How long have you had this issue? 6 months

Have you been treated for this before? No

Medical History Summary

Do you have any of the following conditions?
Asthma

Are you currently taking any medications? Yes
If yes, list medications: Albuterol inhaler

Do you have any allergies? Yes
If yes, list allergies: Penicillin

Have you had any surgeries or hospitalizations? Yes
If yes, list procedures and dates: Tonsillectomy (2000)

Lifestyle & Social History

Do you smoke or use tobacco products? No
Do you consume alcohol? Occasionally
Do you use recreational drugs? No
Occupation: Graphic Designer

Do you have any concerns about access to healthcare, transportation, or financial barriers? No

Pharmacy Information

Preferred Pharmacy Name: Greenfield Pharmacy
Phone Number: (555) 876-5432
Address: 789 Maple Road, Denver, CO 80203

Consent & Signature

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

Signature: Emily Carter

Date: 03/25/2025