PATIENT INTAKE FORM

I. Patient Information

- **Full Name: _____**
- **Date of Birth (DD/MM/YYYY): _____ Gender: _____**
- **Address: _____**
- **Phone Number: _____ Email: _____**
- **Emergency Contact Name: _____ Phone: _____**

II. Medical History

Reason for Visit Today: _____

Are you currently taking any medications? (Yes / No) *If yes, please list:*
_____

Do you have any known allergies (Medication, Food, Latex)? *List:*
_____

Past Medical Conditions (Check all that apply): [ ] Diabetes [ ] Hypertension [ ] Asthma [ ] Heart Disease [ ] Other: **_____**

III. Lifestyle & Social History

- **Do you smoke?** [ ] Never [ ] Former [ ] Current
- **Alcohol Consumption:** [ ] None [ ] Occasional [ ] Frequent
- **Occupation: _____**

IV. Insurance Information

- **Insurance Provider: _____**
- **Policy/Member ID: _____**
- **Group Number: _____**

V. Consent and Signature

I certify that the above information is correct to the best of my knowledge. I authorize the release of any medical information necessary to process insurance claims and request payment of medical benefits to the provider.

Signature: _____ Date: _____