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NEW PATIENT INTAKE FORM

Welcome to our practice! Your completed paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (248) 541-8554 if you have any questions or are unsure how to complete any sections of this form. All information will be strictly confidential. Please print.

First Name: ________________________________ *Last Name:* ____________________________________

D.O.B. _____/______/______ Gender: _______ (M/F/N) Social Security # ______-______-______

Street Address: _______________________________ City/State/Zip: _____________________________

Phone: ( )_________________________ Other Phone (if additional): ________________

Email: _____________________________________ Physical Address Same as Mailing? YES NO

Preferred language ____________________________ Do you need an interpreter? YES NO

Emergency Contact Name: _______________________________ Relation: __________________________

Emergency contact phone: ( )__________________________

Primary Care Physician:

____

Referring Physician (if different from above):

____

May we send your physician a copy of today's visit?

YES NO

Preferred Pharmacy Information:

Name (ie. CVS): _________________________

Address: _____________________________

Phone: ( ) _____________________

☐ Mail order Rx? _____________________

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage. Furthermore, I authorize this office to relate our evaluation to other physicians providing care to me to enhance continuity of care.

Patient/Guardian Signature _____________________________________ **Date:** _______/_______/________