Patient Information			
Name:			DOB *(MM/DD/YYYY)*:
Gender:		Preferred Pronouns:	
Address:			City:
State:	ZIP:	Phone:	
Preferred Contact: ☐ Phone ☐ Email ☐ Text		Email:	
Emergency Contact Name:			Phone:
Relationship to Patient:			

Insurance Information	
Provider:	Policy Number:
Group Number:	Policyholder Name:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____	

Reason for Visit	
Reason:	
How long have you had this issue?	Have you been treated for this before? ☐ Yes ☐ No

Medical History Summary	
Do you have any of the following conditions? ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Cancer _____ Stroke ☐ Other: _____	
Are you currently taking any medication? ☐ Yes ☐ No	If yes, please list:
Do you have any allergies? ☐ Yes ☐ No	If yes, please list:
Have you had any surgeries or hospitalizations? ☐ Yes ☐ No	If yes, please list procedures and dates:

Lifestyle & Social History
Have you ever smoked or used tobacco products? ☐ Yes ☐ No
Do you consume alcohol? ☐ Yes ☐ No ☐ Sometimes
Do you use recreational drugs? ☐ Yes ☐ No
Occupation:
Do you have concerns about access to healthcare, transportation, or financial barriers? ☐ Yes ☐ No
If yes, please list:

PLEASE CONTINUE ON THE REVERSE SIDE.

Pharmacy Information	
Preferred Pharmacy:	Phone Number:
Address:	

Consent & Signature	
I confirm that the information provided is accurate to the best of my knowledge.	
Signature:	Date: