# ESSENTIAL HEALTH& WELLNESS
# PATIENT INTAKE FORM

**PRINT AND COMPLETE ALL ENTRIES**

| FIRST NAME | LAST NAME | DATE OF BIRTH | GENDER/PRONOUN |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY | PHONE #- CELL( ) HOME( ) | EMAIL ADDRESS |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| MARTIAL STATUS<br>S M D W | SPOUSE'S NAME | SPOUSE'S PHONE NUMBER |
|---|---|---|
| | | |

| EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER |
|---|---|---|
| | | |

| EMPLOYER | PHONE # | ADDRESS |
|---|---|---|
| | | |

**INSURANCE INFORMATION**

| DO YOU HAVE INSURANCE?<br>YES NO | PRIMARY POLICY HOLDER NAME | PRIMARY POLICY HOLDER DATE OF BIRTH: |
|---|---|---|
| | | |

| PRIMARY INSURANCE COMPANY | PRIMARY ID NUMBER | PRIMARY GROUP ID |
|---|---|---|
| | | |

| SECONDARY INSURANCE COMPANY | SECONDARY ID NUMBER | SECONDARY GROUP ID |
|---|---|---|
| | | |

**PAYMENT POLICIES**

- YOU ARE FINANCIALLY RESPONSIBLE FOR ANYTHING INSURANCE DOES NOT COVER
- ALL COPAYS ARE DUE AND PAYABLE AT EACH VISIT
- YOUR CLAIM WILL BE PROCESSED ACCORDING TO THE BENEFITS OF YOUR INSURANCE PLAN
- THE DEDUCTIBLE, CO-INSURANCE, AND CO-PAYS ARE YOUR FINANCIAL RESPONSIBILITY
- IT IS YOUR RESPONSIBILITY TO CONTANCT YOUR INSURANCE COMPANY FOR ANY QUESTIONS
- THERE IS A $5 FEE FOR CO-PAYS NOT PAID AT THE TIME OF SERVICE
- ✱ THERE IS A $50 NO SHOW FEE FOR ANY MISSED APPOINTMENT, OR ANY APPOINTMENT CANCELLED OR RESCHEDULED LESS THAN 24 HOURS PRIOR TO THE APPOINTMENT
- IF YOU ARE WITHOUT INSURANCE, ALL CHARGES ARE DUE AT THE TIME OF THE VISIT

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**PRESCRIPTION POLICY**

- PLEASE CONTACT PHARMACY FOR ALL REFILL REQUESTS
- PLEASE ALLOW THREE BUSINESS DAYS FOR ALL PRESCRIPTION REFILLS
- IF YOU HAVE NOT SEEN THE PROVIDER WITHIN 6 MONTHS, THE PRESCRIPTION WILL BE DENIED

| PHARMACY NAME & LOCATION | PHARMACY PHONE NUMBER |
|---|---|
| | |

SIGNATURE: _____ DATE: _____