



# Patient Intake Form

## Patient information

Last name: \_\_\_\_\_

First name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Can a message be left?     Yes     No

Message length:             Brief     Extended

Cell phone: \_\_\_\_\_

Can a message be left?     Yes     No

Message length:             Brief     Extended

Email address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Gender:                     M     F

Date of birth: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Birth hospital: \_\_\_\_\_

**Parent/Guardian #1 name:** \_\_\_\_\_

Previous name (if any): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Employer's name: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Parent/Guardian #2 name:** \_\_\_\_\_

Previous name (if any): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Employer's name: \_\_\_\_\_

Employer phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Other children in the practice:** \_\_\_\_\_

**Name of person responsible for payment of services:**

\_\_\_\_\_

**Pharmacy:** \_\_\_\_\_

Address: \_\_\_\_\_

## Health insurance

Health insurance plan: \_\_\_\_\_

Policy #: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policy holder: \_\_\_\_\_

Secondary insurance plan: \_\_\_\_\_

Policy #: \_\_\_\_\_ Effective date: \_\_\_\_\_

Policy holder: \_\_\_\_\_

I hereby authorize my insurance benefits to be paid to Bridgewater Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Bridgewater Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_