Hear in ARIZONA
*Life never sounded so good!*

# Patient Intake Form

## Patient Information

Patient Name: ______________________ Sex ☐ M ☐ F Date: ____________

Address: ______________ City / State: ______________ Zip: ________

Phone (Home): ______________ Phone (Cell): ______________

Email: ______________ SSN: ______________

Date of Birth: ______________ Age: ______ Marital Status: ☐ M ☐ D ☐ S ☐ W

Occupation: ______________ Employer: ______________

Emergency Contact: ______________ Phone: ________ Relationship: ________

Primary Care Physician: ______________ Phone: ______________

Contact Preference: ☐ Phone ☐ Text ☐ Email     May we also contact you by mail? ☐ Yes ☐ No

## Parent / Guardian / Spouse Information

Name: ______________ Phone: ______________

Address: ______________ City / State: ______________ Zip: ________

Relationship to Patient: ______________

## Insurance Information

Primary Insurance: ______________ Insured's Name: ______________

Address: ______________ City / State: ______________ Zip: ________

Group Number: ______________ Subscriber's Number: ______________

Secondary Insurance: ______________ Insured's Name: ______________

Address: ______________ City / State: ______________ Zip: ________

Group Number: ______________ Subscriber's Number: ______________

Have you previously been seen at our practice? ☐ Yes ☐ No

When? ______________ Reason? ______________

## How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Patient Referral: ______________

☐ Advertisement ☐ Insurance ☐ Physician: ______________

☐ Educational Seminar ☐ Employer ☐ Other: ______________

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