English Español — FAMILY PRACTICE INTAKE

New Patient Form

Complete the form below and hit send — it goes straight to our front-desk team, so we can have your chart ready before you arrive. Fields marked * are required.

1 Patient information

First name *

Last name *

Date of birth *

mm/dd/yyyy

Sex *

Select...

Marital status

Select...

Street address *

City *

State *

AZ

ZIP *

Mobile phone *

Alt. phone

Email

Preferred contact method

Select...

Employer / school

2 Parent or guardian (if patient is under 18)

Parent / guardian name

Relationship to patient

Parent / guardian phone

Parent / guardian email

3 Emergency contact

Full name *

Relationship

Phone *

4 Insurance

Primary insurance carrier

e.g., Medicare, AHCCCS, Blue Cross...

Member / policy ID

Policyholder name (if not patient)

Policyholder date of birth

mm/dd/yyyy

Secondary insurance (if any)

Secondary member / policy ID

This visit is related to a workers' compensation claim

No

5 Pharmacy & reason for visit

Preferred pharmacy

Pharmacy location / cross streets

Reason for today's visit / main health concern

Tell us briefly what brings you in...

6 Medical history

Please check any conditions you have or have had:

- [ ] Asthma
- [ ] Allergies / hay fever
- [ ] High blood pressure
- [ ] Diabetes
- [ ] High cholesterol
- [ ] Heart disease
- [ ] Thyroid disorder
- [ ] Cancer
- [ ] Depression / anxiety
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Seizures
- [ ] Stroke
- [ ] GERD / acid reflux
- [ ] Arthritis

Other conditions, past surgeries or hospitalizations (with year)

e.g., Appendectomy 2016; tonsillectomy 2004…

7 Medications & allergies

Current medications & dosages

List each medication, dose, and how often (or write None)…

Medication / food / environmental allergies & reactions

e.g., Penicillin — rash (or write No known allergies)…

8 Family & social history

Family history of significant illness (parents, siblings)

e.g., Father — diabetes; mother — high blood pressure…

Tobacco use

Select…

Alcohol use

Select…

Exercise

Select…

9 Acknowledgment & signature

By submitting this form, I certify that the information provided is accurate to the best of my knowledge. I understand this form is a registration request and does not establish care until confirmed by the office. I acknowledge that I have been offered the clinic's Notice of Privacy Practices.

☐ I have read and agree to the acknowledgment above, and to the **Privacy Policy** and **Terms & Conditions**. *

Signature (type your full name) *

Date *

mm/dd/yyyy