Patient Information			
Name			DOB *(MM/DD/YYYY):*
Gender: □ Male □ Female □ Other: _____		Preferred Pronouns: □ He/Him □ She/Her □ They/Them □ Other: _____	
Address:			City
State:	Zip:	Email:	
Phone:		Preferred Contact Method: □ Phone □ Email □Text	
Emergency Contact Name:			Phone:
Relationship to Patient			
Insurance Information *(if applicable)*			
Provider:		Policy number:	
Group Number:		Policyholder Name	
Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____			
Reason for Visit			
Primary Reason for Visit:			
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? (Check all that apply) □ Diabetes □ Hypertension □ Heart Disease □ Asthma □ Cancer □ Stroke □ Other: _____			
Are you currently taking any medications? □ Yes □ No		If yes, list medications:	
Do you have any allergies? □ Yes □ No		If yes, list allergies:	
Have you had any surgeries or hospitalizations? □ Yes □ No		If yes, list procedures and dates:	
Lifestyle & Social History			
Do you smoke or use tobacco products? □ Yes □ No □ Former Smoker			
Do you consume alcohol? □ Yes □ No □ Occasionally			
Do you use recreational drugs? □ Yes □ No			
Occupation:			
Do you have any concerns about access to healthcare, transportation, or financial barriers? □ Yes □ No			
If yes, please describe: _____			
Pharmacy Information			
Preferred Pharmacy Name:		Phone Number:	
Address:			
Consent & Signature			
☐ I confirm that the information provided is accurate to the best of my knowledge.			
Signature:			Date: