Advanced Medical Care
PATIENT INTAKE FORM

Please print, fill out and bring to your first visit.

NAME_________________________________**DOB**_____________
Please print full name

ADDRESS_________________________________**Sex**:___________

CITY, STATE, ZIP CODE_____________________________________

EMAIL ADDRESS____

PHONE: Home____________Work_____________Cell____________

Circle: **Drivers License or State ID**, #______________State__________

CIRCLE MARITAL STATUS

MARRIED, SINGLE, DIVORCED, SEPARATED, DOMESTIC PARTNER , WIDOWED

Social Security Number_____________________________________

EMERGENCY CONTACT

NAME___________________**PHONE NUMBER**__________________

INSURANCE INFORMATION

Insurance Carrier______________**Insurance Plan**________________

Please bring your insurance card for staff to copy.

Secondary Insurance_______________________

PREFERRED PHARMACY_____________________________________