SILVER LAKE WELLNESS CENTER

Patient Intake Form

_____ _____ Male / Female

Name Birthdate

_____

Address City State Zip

_____ _____ _____

Daytime Phone Evening Phone Cellular

_____ May we contact you via email? Yes / No

Email Address

_____ _____ _____ _____

Social Security Marital Status # of Children Referred By

MEDICAL:

List all Allergies: (Foods/Medications) _____

_____ _____ _____

Emergency Contact: Name Relationship Phone

_____ _____

Primary Care Physician: Name Office Phone

EMPLOYMENT:

_____ _____

Employer Occupation

_____ _____

Address Business Phone

INSURANCE:

_____ _____ _____

Primary Insurance Company Member ID/Subscriber ID Group #/Policy #

_____ _____ _____

Claims Address City State Zip

_____

Policy Holders Name & Address