

# SILVER LAKE WELLNESS CENTER

## Patient Intake Form

\_\_\_\_\_  
Name Birthdate Male / Female

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Daytime Phone Evening Phone Cellular

\_\_\_\_\_  
Email Address May we contact you via email? Yes / No

\_\_\_\_\_  
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