Patient Intake Form

PATIENT INFORMATION

INTEGRATED
PHYSICAL | MEDICINE

Date

Full Name
First MI Last

Address City State Zip

Age Birth Date Female Male Race Pref. Language

Home Phone Work Phone Cell/Other

I prefer to receive calls at ☐ Home ☐ Work ☐ Cell Cell Phone Provider *(for text reminders)*

Email Address *(for IPM use only)*

I am ☐ Under Age 18 ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Employed Occupation ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Retired

Business Address City State Zip

Spouse's Name Spouse's Date of Birth

Emergency Contact Emergency Contact Phone #

Payment Information Person Responsible for Payment

Relationship Phone Date of Birth

Insurance Information Do you have health insurance? Yes No

Primary Insurance

Insurance Company

Policy Holder's Name

Relationship to Patient

Policy Holder's Birth Date

Group Number

Policy ID Number

Secondary Insurance

Insurance Company

Policy Holder's Name

Relationship to Patient

Policy Holder's Birth Date

Group Number

Policy ID Number

Please have your health insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release - *By signing below, I authorize Integrated Physical Medicine, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Integrated Physical Medicine, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed Date