CREDO
FAMILY MEDICINE

Patient Intake Form

- Name: *First*:_____ *Middle*: _____ *Last*:_____

Date of Birth: _____/_____/_____ Gender: ____Male ____Female SSN:_____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____

Email Address: _____

Marital Status: ____ Single ____ Married ____ Legally Separated ____ Widowed

- Guarantor: _____
- ***Emergency Contact:*** _____

Phone: (_____)_____ ***Relationship to Patient:*** _____

- Primary Employer: _____
- Preferred Pharmacy: _____ • *How did you hear about us*? _____

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1 **Primary Insurance**: _____

Policy Holder Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Gender: ___Male ___ Female

Address: _____

Employer: _____

Phone No.: (_____)_____

2 **Secondary Insurance**: _____

Policy Holder Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Gender: ___Male ___ Female

Address: _____

Employer: _____

Phone No.: (_____)_____

3 **Tertiary Insurance:** _____

If the policy holder information is the same as listed above, please indicate which information applies: **1** ___ **2** ___