



## Adult Intake Form

Date: \_\_\_\_\_

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Gender:  M  F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS # \_\_\_\_\_

Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_

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

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

Can we text your appointment reminders?  Yes  No (Please be sure cell phone number is provided.)

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

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

### EMERGENCY CONTACT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Relation to the patient \_\_\_\_\_

### CONSENT TO TREAT

A patient coming to the doctor gives the doctor permission and authority to care for the patient in accordance with appropriate tests, diagnoses, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not provide specific healthcare if she is aware that such care may be contraindicated. It is the responsibility of the patient to inform the doctor of any and all health conditions by sharing a detailed health history, in its entirety.

I have read and understand the foregoing, and I **certify** that the above information is correct.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_