New Patient Intake Form

Today's Date:_____

Patient Name:_____

Patient Mailing Address:_____

Date of Birth:_____

Home Phone #:_____ **May we leave a message?** ☐ **YES** ☐ **NO**

Cell Phone #:_____ **May we leave a message?** ☐ **YES** ☐ **NO**

Email:_____

Local PCP/Other Doctors/Specialists:_____

_____

Cardiologist: ☐ **YES** ☐ **NO**

Medication(s) and vitamins/supplements currently taking:_____

_____

_____

_____

_____

Emergency Contacts/Relationship/Phone Number:_____

_____

Primary Insurance:_____

Subscriber #:_____ **Group #:**_____

Secondary Insurance:_____

Subscriber #:_____ **Group #:**_____

To ensure all patients can be seen in a timely manner, patients will be seen by Dr. Purush and or Tess Barnes, NP-C.

***Please initial showing you understand this*:** _____

**********Below is for office use only**********

ACCEPTED:_____ **NOT ACCEPTED:**_____

New Patient Appt. Time & Date: _____

APURVA STAFF, PLEASE MAKE COPY OF INSURANCE CARD(S)*