PATIENT INTAKE FORM-2026

Please answer the following questions so we can comply with Medicare.

Today's Date_____

Name_____ Date of birth_____

1) Do you smoke? (circle one) Current Former Never

2) Do you have an Advanced Care Plan? Yes No

If yes, who is the decision maker on that plan?

Name_____Phone number_____

Relationship_____

3) What is the name of your primary care provider?

_____

We now have a secure patient portal to allow patients to access

medical records and communicate with our staff.

Please print clearly the information requested below.

Patient name_____

Patient email address_____

___I do not wish to give my email. ___I do not have an email address.

Updated 02/23