CENTER FOR COMPLEX NEUROLOGY
EDS & POTS

Patient Intake Form

Patient's Name (Last, First,MI): ______________________________

Patient's Primary\ Phone Number:______________ Permission to leave message? yes no

E-Mail Address:______________________@______________

Address: ______________________________ Apt. # __________

City: ______________________ State:__________ Zip: __________

Date of Birth: __________ Age:________ Gender: M F Social Security Number: ______________

Patient's Employer: ______________________

Patient's Occupation: ______________________

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: __________

Emergency Contact:______________________ Relationship to Patient: ______________

Address:______________________ Phone number: ______________

INSURANCE INFORMATION

Primary Insurance:______________

Patient is Subscriber/Policy Holder: Y N

PLEASE scan or photograph a both sides of your insurance cards and submit with this form.

Secondary Insurance: ______________

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT)

Subscriber/ Policy Holder:______________________ Relationship to Patient: ______________

Address:______________________________

Social Security Number: ______________________

Date of Birth: ______________________

Subscriber Employer:______________________ Work Phone Number: ______________________

Patient / Parent or Guardian Signature:______________________________ Date: ______________

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Date: _______________

PERSONAL INFORMATION

Patient Name:____Birth Date:____/___/_______Age:_______

Names/Specialties/Locations of Other Physicians Caring for You, including primary care doctor: ___________________

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____

CURRENT MEDICATIONS: Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page, if needed also) or attach a list:

Medication Name	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): ____

____

____

Pharmacy Name and Phone:____

Surgeries you've had with Month and Year____

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