

Adult New Patient Intake

Please complete prior to your first appointment. Return via the secure patient portal or bring to your visit.

Patient Information

Full Legal Name

Preferred Name

Date of Birth

Phone (best contact)

Email

Street Address

City / State / ZIP

Emergency Contact

(Name & Phone)

Primary Care Provider

Insurance

Insurance Carrier

Member ID

Group #

Policy Holder Name &

DOB

Reason For Visit

Briefly describe what brings you in today

Current Medications (Name, Dose, Frequency)

Allergies

Past Psychiatric / Medical History

Patient/Guardian Signature: _____ Date: _____