Health Service Alliance

Intake Form

Patient Information:

Full Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Phone: _____ ☐ Home ☐ Cell

Social Security Number: _____ Primary Language: _____

Racial/Ethnic Background: ☐ Hispanic/Latino ☐ Asian ☐ Pacific Islander ☐ American Indian

☐ Black/African American ☐ White/Caucasian ☐ Other: _____

Address: _____ City: _____

State: _____ Zipcode: _____ County: _____

If homeless please indicate: ☐ Shelter ☐ Temporary housing ☐ Unsheltered

Additional support needed: ☐ Housing assistance ☐ Case management ☐ Food insecurities ☐ Transportation

Emergency Contact: _____ Emergency Contact Phone: _____

Health Insurance:

Insurance Company: _____ Subscriber: Yes ☐ No ☐

Policy ID Number: _____ Group Number: _____

Policy Holder Name: _____ Subsciber DOB: _____

Relationship: _____ Subscriber SSN: _____

Medical History:

Chief complaint: _____ Past medical treatmet: _____

Medication Management: Are you currently on any medication? ☐ Yes ☐ No

If yes, please list your medication(s) and dosage: _____

Do you have any allergies: _____

Preferred pharmacy: _____

I understand that my information will remain confidential and that Health Service Alliance follows HIPPA and state laws to prtect my privacy.

Patient Signature: _____ Date: _____

If under 18, must be signed by a legal parent/guardian

Parent/Guardian Signature: _____ Date: _____