CLIENT INTAKE FORM

Client Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information:

Provider Name: _____

Policy Number: _____

Group Number (if applicable): _____

Medical History and Conditions:

Please list any medical conditions, allergies, medications, or other relevant health information the provider should be aware of. Use additional pages if necessary.

Consent and Authorization:

I hereby authorize the provider and its staff to provide medical care and treatment deemed necessary in the event of an emergency or as part of the services rendered. I acknowledge that I have provided accurate and complete information to the best of my knowledge. I understand that this form is legally binding and enforceable under United States law.

Privacy and Data Use:

I understand the provider's privacy practices and consent to the collection, use, and disclosure of my personal information in accordance with applicable laws and regulations, including HIPAA. I may request a copy of the privacy notice at any time.

Client Signature: _____ **Date:** _____

Provider Representative Signature: _____ **Date:** _____

CLIENT SIGNATURE **PROVIDER REPRESENTATIVE SIGNATURE**

Signature: _____ Signature: _____