Example Patient Intake Form for Medication Administration Services

Patient Information

Patient Name

First Name_____ Middle Initial_____Last Name_____

Sex/gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Date of Birth _____/_____ /_____

Street _____

City _____State_____Zip _____

Home Phone _____

Work Phone_____Mobile Phone _____

Email Address _____

Patient's Employer _____

Occupation _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ White ☐ Black/African-American ☐ Hispanic/Latino ☐ Asian/Pacific American
☐ Native American ☐ Other:_____

Emergency Contact

Name_____

Relationship to Patient _____

Home Phone _____

Work Phone_____Mobile Phone _____

Primary Insurance

Insured's Name

First Name_____ Middle Initial_____Last Name_____

Relationship to Patient _____

Insured's Date of Birth _____/_____ /_____

Insured's Address (if different from patient's)

Street _____

City _____State_____Zip _____

Insured's Phone Number _____

Insured's Employer _____

Insured's Occupation _____

Insurance Plan Name _____

Insurance Policy/ID Number_____Insurance Group Number _____

Insurance Company Phone Number _____

Secondary Insurance

Is this patient covered by additional insurance? ☐ Yes ☐ No

Insured's Name

First Name_____ Middle Initial_____Last Name_____

Insured's Relationship to Patient _____

Insured's Date of Birth _____/_____ /_____

Insured's Address (if different from patient's)

Street _____

City _____State_____Zip _____

Insured's Phone Number _____

Insured's Employer _____

Insured's Occupation _____

Insurance Plan Name _____

Insurance Policy/ID Number_____Insurance Group Number _____

Insurance Company Phone Number _____

General Practitioner

Physician Name_____

Address

Street _____

City _____State_____Zip _____

Phone Number_____Fax Number _____