Reid Health
Physician Associates

PATIENT INTAKE FORM

Date/Time: _____

Desired Physician:_____ Previous Patient: Y N

Patient Name (last, first, middle initial): _____Sex: M F

Guarantor if < 18: _____

Email Address:___ _____ Date of Birth: _____ Marital Status: S M D W

Patient Address: _____City:_____State:_____Zip:_____

Phone Numbers: (H) _____(C)_____(W)_____

Last Primary Physician: _____ Referred By: _____

Employer Name:_____ Status: Full-Time Part-Time Retired None

Primary Insurance: _____ Secondary Insurance: _____

Student Status if applicable: Full-Time Part-Time Name of College/Univ/School.:_____

Medical Problems:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Medicare Wellness Visit_____

Follow Up by Practice: _____

Practice Accepting Patient:_____ Physician: _____

New Patient Appt Scheduled: Y N Appt Date/Time: _____

Signature: _____

Please fax to: **765-983-7918** : or mail to Practitioner Referral Line 1100 Reid Parkway Richmond, IN 47374

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