Journey Healthcare

New Patient Intake Form

Demographic Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Social Security # _____ Date of Birth: _____

Insurance

Payer Name: _____ Subscriber Name: _____

Member ID: _____ Group Number: _____

Secondary Insurance

Please list additional secondary insurance

Payer Name _____ Subscriber Name: _____

Member ID:: _____ Group Number: _____

Reason for treatment

Diagnosis/Complaint _____

Reason for Visit _____

Appointment

Provider _____ Date: _____

Appointment _____ Time: _____