Atlas Infectious Disease Practice

JOSEPH H. ETIENNE, MD
Board Certified, Infectious Diseases

INTAKE FORM

NAME: (Last) ______________________ (First) ____________________ (MI) ______

DOB: ________________ **AGE**: ________________ **SEX**: ________________

SOCIAL SECURITY #: ____________________ **LIVING WILL**: YES _____ OR NO ______

STREET ADDRESS: ____

CITY: __________________________ STATE __________ **ZIP CODE**: ____________

PHONE: (Home) ______________ (Cell) ________________ (Work) ______________

E-MAIL 1: ____________________________ **E-MAIL 2**: _________________________

MARITAL STATUS: Single___ Married ___Widowed ___ Divorced ___

RACE: (Please Circle) American Indian or Alaskan Native (**Al**), Asian (**A**), Black (**B**), Caucasian (**C**), Other (**E**), Pacific Islander (**P**), Declined ( ).

ETHNICITY: ________________________ **PLACE OF BIRTH**: ______________________

OCCUPATION: _________________________ **EMPLOYER**: _________________________

EMERGENCY CONTACT: ____

PHONE: ____________________________ **RELATIONSHIP**: _______________________

PRIMARY PHYSICIAN: ________________ **REFERRING PHYSICIAN**: __________________

ALLERGIES: ____

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CURRENT MEDICATIONS: ____

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PHARMACY: __________________________ **PHONE#**: __________________________

PREFERRED LAB: ______________________________

5401 S. Congress Ave, Suite 201, Atlantis, FL - 33462
phone: (561)995-6971
Fax (561)569-8309