Atlas Infectious Disease Practice PLLC

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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 (**AI**), 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: _____

_____

CURRENT MEDICATIONS: _____

_____

PHARMACY: _____ **PHONE#:** _____

PREFERRED LAB: _____

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