



## Bailey Health – New Patient Health Intake Form

Welcome to Bailey Health! Please complete the following form to help us better understand your health needs. All information will remain confidential.

### Patient Information

Full Name:	
Date of Birth:	
SS #:	
Gender: (M or F)	
Home Phone:	
Mobile Phone:	
Work Phone:	
Patient's Email Address:	
Address:	
City:	
State:	
ZIP Code:	
Language:	
Race:	
Ethnicity:	
Marital Status:	
<b>Other:</b>	
Emergency Contact Full Name:	
Emergency Contact Phone and Address:	
Relationship:	

### Insurance Information

If no insurance circle: <b>Self Pay</b>	List Primary Insurance:	List Secondary Insurance:
Insurance Provider:		
Policy Number:		
Group Number:		
Insurance Phone Number:		
Insurance Address:		
Subscriber Name:		
Subscriber Date of Birth		
Patient's relationship to policy holder:		



## Medical History

Primary Care Physician:	
Patient Referred By: (address and phone #)	
Preferred Pharmacy with address and phone #: (e.g., Walgreens, CVS)	
Preferred Lab Facility with address and phone #: (e.g., Quest Lab)	
Preferred Imaging Facility with address (e.g., Midstate Radiology)	
Current Medications (if any):	
Known Allergies:	
Past Surgeries or Hospitalizations: (If space is needed, use below)	
Chronic Conditions (e.g., Diabetes, Hypertension, Cholesterol)	
Family Medical History: (if space is needed, use below)	
Lifestyle (e.g., diet, exercise, tobacco/alcohol use):	

## Reason for Visit

Please describe the reason for your visit today (current symptoms or concerns) and any additional information:	

## Lifestyle & Social History

Do you smoke: Yes / No	
Do you drink alcohol? Yes / No	
If you exercise? How frequent?	

## Consent & Signature

I certify that the above information is accurate to the best of my knowledge.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If patient unable to sign)