Georgia Osteopathic Care Center

PCOM Georgia

Patient Intake Form

Name _____ Today's Date: ____/ ____ / _____

Address _____ Billing Address (if different)

_____ _____

_____ _____

Phone Home: _____ Cell: _____

Email _____

Preferred method of contact: Home phone ____ Cell ____ Email _____

Ok to leave a message? YES / NO

Personal D.O.B ____/____/_____ Male / Female Race _____

Preferred Language _____

Pharmacy _____ Phone_____

Emergency Contact Information

Name _____ Phone _____

Relationship to Patient _____

If Patient is a Minor

Name of Responsible Party _____

Relationship to Child _____

If the child is living with one parent, is it okay to give information to the other parent?

YES / NO

Parent's Information

Mother's Name _____ D.O.B. ____ / _____/ _____

Father's Name _____ D.O.B. ____ / _____/ _____

Will you be submitting these charges to your insurance company? YES / NO

Insurance Information

Name of Insurance Company _____

Name of Policy Holder _____ Policy Holder D.O.B. __/___/_____

Member ID _____ Group ID _____

This information is necessary to process any claims from your insurance company so that you can be reimbursed.

How did you hear about us? _____

_____

_____

Referred by: _____