



# New Patient Intake Form

**First Name**  **MI**  **Last name**  **Date of Birth (mm/dd/yyyy)**

**Address**  **City**  **State**  **ZIP**

**Mobile Number**  **Other Number**  **Email**

**Primary Language**  English  Español  Other \_\_\_\_\_

**Race (Select all that apply)**

American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or other Pacific Islander  Caucasian/White

**Ethnicity**

Hispanic  
 Other \_\_\_\_\_

**Marital Status**

Single  Married and living with spouse  Married but separated with spouse  
 Not married but living with other person  Divorced  
 Widow or Widower  Other \_\_\_\_\_

**Sex**

Male  
 Female

**Highest Educational Level Achieved**

Did Not Graduate High School / Highest grade achieved \_\_\_\_\_  
 High School Degree / GED  2 Years College / Some College  College or Graduate Degree

**Employment Status (Select all that apply)**

Full Time (30+ hours/week)  Part Time (Less than 30 hours/week)  Working at home  Unemployed  
 Full-time Student  Part-time Student  Disabled  Retired

**Do you have an identification card?**  Yes  No *You will need to bring it with you to your first appointment.*

**Total annual Income of everyone living in the home with you, combined together** \$

**Do you have health/medical insurance?**  Yes  No

**Any other information you would like to share?**

**How did you hear about the clinic?**

TV  Radio  Church  Friend  Health Fair  Newspaper  Internet search  
 Sign on the Street/Drive by the clinic  Other \_\_\_\_\_