



New Patient Intake Form 2020

DENTAL USE ONLY:
80% 60% 40%

PATIENT INFORMATION:

Name: Middle Initial:
(LAST/SURNAME) (FIRST NAME)

Date of Birth: Age:
(MONTH) (DAY) (YEAR)

Gender: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Gender Nonconforming
☐ Other gender identity not listed above: ☐ Prefer not to answer

Address: County:

City: State: Zip:

Language(s): Interpreter Needed: ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Veteran: ☐ Yes ☐ No

Race/Ethnicity:

☐ African ☐ Pacific Islander ☐ American Indian/ Alaska Native ☐ Multiracial
☐ African-American/Black ☐ Caucasian ☐ Unknown
☐ Asian ☐ Latino/Latina ☐ Arab/Middle Eastern

CONTACT INFORMATION:

Phone(Primary): ☐ Cell ☐ Home ☐ Other:

Phone(Secondary): ☐ Cell ☐ Home ☐ Other:

We may need to contact you. Please check all that we have your permission to leave messages on or with:

☐ Voicemail/Texting ☐ SPECIFIC Person ONLY, provide the name(s):

☐ Check here to opt out of receiving text messages

☐ Another Person:

Please list an EMERGENCY contact below:

(FULL NAME) (PHONE) (RELATIONSHIP)

Please list any hospitalizations, surgeries, or ER visits you have had.

1. Date: 2. Date:
3. Date: 4. Date:

MEDICAL/DENTAL RECORDS:

I am currently connected to Lahai Health for: ☐ Dental ☐ Medical ☐ Mental Health Counseling

Are you currently connected to another clinic for medical, dental, or mental health counseling care services? ☐ No ☐ Yes

Staff Initials: _____ Patient Name: _____ INTAKE 1

Formerly Puget Sound Christian Clinic

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

Do you have dental, medical, or mental health counseling records that you would like to have sent to us from past or current clinics?

☐ No ☐ Yes (Please ask reception for a Release of Information form and we will request the records)

INSURANCE INFORMATION:

HEALTH:

Do you have any forms of health insurance right now? ☐ No ☐ Yes

If yes, please identify the type of coverage you have below and *provide a copy of your card to reception*. Common types are (Medicaid/Apple Health, Medicare, Veteran Benefits, or contracted from the Health Exchange)

Insurance Plan: Yearly Deductible: \$

If no, have you ever applied for Health insurance? ☐ No ☐ Yes Date Applied:

(If you applied and were denied coverage, please provide a copy of denial letter to reception.)

DENTAL:

Do you have any dental insurance? ☐ No ☐ Yes

If yes, please identify what type of insurance you have and provide a copy of your card to reception (Medicaid/Apple Health, Delta Dental, etc.)

Dental Insurance:

HOUSEHOLD INFORMATION:

Country or Origin: Years in US: Are you a visitor? ☐ Yes ☐ No

If Yes: What is the date of arrival: Date of Departure:

Reason for visit: (Refugee/Asylee, Family, Type of Visa, etc):

(If you are applying for asylum, please provide a copy of Asylum application to reception)

HOUSEHOLD INFORMATION:

Your annual income and your family size are necessary to determine your eligibility. Your answers will be kept on file and in strict confidence.

Please choose 1 from the list below to verify your income:

1. Income tax return from the previous year
2. A copy of your W-2 form
3. Two months of paycheck stubs
4. Two months of bank statements
5. Copies of your social security checks or letter, or other checks you may receive.

You must verify your income every year. Please bring a copy to your appointment.

Are you employed? <input type="checkbox"/> No <input type="checkbox"/> Yes	Patient's Monthly Employment Income: <input type="text"/>
Is your spouse/partner employed? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes	Spouse/Partner's Monthly Employment Income: <input type="text"/>
How many people are supported with the total household income? <input type="text"/>	

Does anyone else in your household have any form of income that supports you (spouse, parent, etc.)? If so, please fill out the following:

Other Income	
Social Security:	\$ <input type="text"/>
Food Stamps:	\$ <input type="text"/>
Public Assistance:	\$ <input type="text"/>
Retirement Pension:	\$ <input type="text"/>
Child Support, Alimony:	\$ <input type="text"/>
Other:	\$ <input type="text"/>
TOTAL:	\$ <input type="text"/>

I do hereby swear or affirm that the information provided above is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for programs at Lahai Health. I further agree to inform Lahai Health if there is a significant change in my income. If acceptance to the Lahai Health programs is obtained under this application, I will comply with all rules and regulations of Lahai Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

Patient Digital Signature: Date:

Staff Initials: _____ Patient Name: _____ INTAKE 3

PATIENT PRIVACY AGREEMENT

This notice describes how your medical and personal information may be used and disclosed at Lahai Health. Your protected private information includes personal and demographic information such as your name, address, date of birth, various identification numbers and phone numbers. It also includes all health information relating to your past, present, and future physical or mental health conditions.

We use and disclose your private information in many ways when providing you with care. If our healthcare providers ask you to see a specialist, we may disclose your name and reason for referral to the specialist. If a pharmacy calls us with a refill request, we may confirm your information with them. When we send a specimen to the laboratory, we disclose your name and other demographic information to them. This type of disclosure between our healthcare providers and other care providers is necessary to provide you with the best and most effective care. Your primary health care team may include, but is not limited to: providers, nurses, dietitians, spiritual care & physical therapists.

There are situations where we may release your information without your expressed consent. These situations include but are not limited to: emergencies, required reporting to public health entities, and as required by law enforcement agencies. You may have rights regarding our use of your private information. You have the right to limit disclosure (in writing) of your information. You have the right to know if we disclose your information for non-routine health care purposes. You have the right to see your medical records and request amendments or corrections. This notice will be kept on file. You may file a complaint regarding the disclosure of your information to our Clinic Director.

I have read and understand the agreement above between Lahai Health and myself regarding the privacy of my information. This agreement will remain in effect until it is revoked in writing by the undersigned.

Patient Digital Signature:

Date:

CONSENT FOR DENTAL, MEDICAL or COUNSELING TREATMENT

Choose all that apply: ☐ Dental ☐ Medical ☐ Mental Health Counseling

In order to receive quality care, I authorize the release of my medical, dental or mental health counseling information to Lahai Health in order to provide me with care. I authorize Lahai Health to release my medical records to other health care providing agencies for the purpose and benefit of providing health care to me.

I hereby give consent to receive medical, dental or counseling care from Lahai Health and its providers and healthcare staff. If patient is a minor, the patient's parent/guardian must consent to care and treatment. I understand that there are exceptions when care can be obtained by a minor without parental or guardian consent, based on Washington State law and Federal law.

The information provided on my intake paperwork is accurate to the best of my knowledge and I will inform Lahai Health of any changes in my health, medications, health insurance status, income or contact information.

Privacy Practices are listed above in the "Patient Privacy Agreement". I understand that I can obtain a personal copy, upon request.

This authorization will remain in effect for any care received through Lahai Health until it is revoked in writing by the undersigned.

Patient Digital Signature:

Date:

FINANCIAL AGREEMENT

THERE IS A \$20.00 DEPOSIT TO MAKE ALL APPOINTMENTS. The \$20.00 will be credited to your account at the completion of the appointment. However, if the appointment is

Initial

Cancelled with less than 48 hours' notice.

Initial

If you do not show up for your appointment,

Initial

If you arrive more than 10 minutes late for your appointment

Initial

If \$20.00 deposit becomes NON-REFUNDABLE;
I understand that a \$20.00 deposit is required to remake the appointment.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at each appointment. We accept cash and major credit cards. All emergency dental services or any dental service performed without previous financial arrangements must be paid for at the time of service.

If you will not be the financial responsible party and or someone else will be covering the costs of your dental services, please share that information below. If you are the responsible party, please skip the "Financial responsible party section, but sign and date.

FINANCIAL RESPONSIBLE PARTY (if not the patient)

Name: Relationship:

Address:

County:

City: State:

Zip:

Home Phone: Cell Phone:

I have read, fully understand, and agree to the above financial policy.

Patient Digital Signature: Date:

LAHAI HEALTH MISSED APPOINTMENT POLICY

It is important that Lahai Health patients keep their appointments. When a patient doesn't show up for a scheduled appointment, cancels last minute, or arrives late, the clinic's *very limited resources* are wasted when Lahai Health could have served another patient in need of care.

Rescheduling Appointments

To reschedule, please call Lahai Health (206-363-4105 MEDICAL: Ext 230, DENTAL: Ext 701, COUNSELING: Ext 231) as soon as you know that you will not be able to keep the appointment, ***at least 48 hours prior to your appointment time***. Please leave a message on the scheduling line if your call is not answered.

Missed Appointments

If you miss a scheduled appointment completely, cancel with less than 48 hours' notice, or arrive more than 10 minutes late, this will be recorded in your electronic chart. **Please note if you arrive late, you may have to be rescheduled, if there is not enough time to complete your visit or procedure.**

If you have 2 missed appointments (includes late cancels or late shows) within a 1-year time frame, you will not be able to schedule with Lahai Health for a period of 6 months. You will receive a letter from clinic staff notifying you of the date you may return for care.

I understand the Lahai Health Missed Appointment Policy and agree to follow the terms of this policy.

Patient Digital Signature: Date:

Staff Initials: _____ Patient Name: _____ INTAKE 5

SOCIAL HISTORY:

Where are you currently living? ☐ House ☐ Apartment ☐ Car ☐ Homeless/Unstable Housing ☐ Other:

Do you feel safe in your current relationship? ☐ No ☐ Yes

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I prefer not to answer.

Number of Lifetime Sexual Partners: Number of Sexual Partners in the Last Year:

Use of Caffeine (Coffee/Tea/Soda): ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously, but I quit.

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously, but I quit.

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously, but I quit.

Use of Marijuana: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously, but I quit.

Use of Recreational Drugs: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Previously, but I quit.

Exercise: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, Types of Exercise:

SPIRITUAL CARE:

Would you like for someone to pray with/for you or help with faith-based questions? ☐ Yes ☐ No

Do you have other concerns? (For example: Housing, food stamps, Financial assistance, or transportation): ☐ Yes ☐ No
If you answered yes to any of the above, please ask receptionist to speak with the patient advocate.
(Dental: please see receptionist.)

***How did you hear about Lahai Health?

☐ Online ☐ Goodwill Screening ☐ Church:

☐ Lahai Health Volunteer ☐ Family/Friends ☐ Other:

***WHEN PAGES 1-6 ARE COMPLETE, PLEASE HAND TO THE RECEPTIONIST WITH A FORM OF ID, ANY INSURANCE CARDS, AND FINANCIAL DOCUMENTATION YOU BROUGHT. ***

RECEPTION USE ONLY:

- ☐ Clinic Site: _____
- ☐ Copy of Identification (ID) provided (*indicate type*): _____
- ☐ Financial Documents provided (*indicate type*): _____
- ☐ Copy of Insurance Cards provided (*only for patients with any insurance*)
- ☐ Explanation of Financial Standing form completed (*if applicable*)
- ☐ ROI for dental/medical records completed (*if needed*)
- ☐ Signed medical interpreter form (if applicable indicate type): _____
- ☐ Signed Text Messaging(SMS) consent (if applicable)
- ☐ Specify what percentage patient falls under the Federal Poverty Level
(Refer to the FPL chart): _____ %
- ☐ **FOR DENTAL USE ONLY:** Circle what percentage discount the patient is approved for: 80% 60% 40%

Staff Initials: _____ Patient Name: _____ INTAKE 6

PATIENT MEDICAL INFORMATION AND HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

GENERAL QUESTIONS

Are you under a physician's care now? ☐ YES ☐ NO If yes, who is your physician:

What is your impression of your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any of the following disease or problems?

Active Tuberculosis? Yes ☐ No ☐

Persistent cough greater than 3 weeks in Yes ☐ No ☐

Cough that produces blood? Yes ☐ No ☐

Been exposed to anyone with Tuberculosis? Yes ☐ No ☐

Have you ever...

Been hospitalized or had a major operation? Yes ☐ No ☐

Had a serious head or neck injury? Yes ☐ No ☐

Had an organ transplant? Yes ☐ No ☐

Had a joint replacement? Yes ☐ No ☐

Had a history of Infective Endocarditis? Yes ☐ No ☐

Had an eating disorder? Yes ☐ No ☐

Taken Phen-Fen or Redux? Yes ☐ No ☐

Taken oral bisphosphonates: Yes ☐ No ☐

ex. Fosamax, Boniva, Actonel

Taken IV bisphosphonates Yes ☐ No ☐

ex. Bonefos, Aredia, Reclast, Zometal

Do you use...

Tobacco? Yes ☐ No ☐

Controlled substances? Yes ☐ No ☐

Alcohol beverages? Yes ☐ No ☐

Are you dependent on...

Tobacco? Yes ☐ No ☐

Controlled substances? Yes ☐ No ☐

Alcohol beverages? Yes ☐ No ☐

Women, are you...

☐ Pregnant / Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

☐ None of the above

ALLERGIES

Are you allergic to any of the following?

☐ None ☐ Latex ☐ Barbiturates, Sedatives, or sleeping pills

☐ Penicillin ☐ Sulfa Drugs ☐ Codeine

☐ Aspirin ☐ Local Anesthetics ☐ Other:

If Yes, what happens?

Staff Initials: _____ Patient Name: _____ INTAKE 7

Formerly Puget Sound Christian Clinic

CURRENT SYMPTOMS: Indicate if you experience any of the items below by checking the box.

Cardiovascular / Heart Problems?

Congenital heart defects	Y <input type="checkbox"/> N <input type="checkbox"/>	Angina (chest pain)	Y <input type="checkbox"/> N <input type="checkbox"/>	Shortness of breath	Y <input type="checkbox"/> N <input type="checkbox"/>
Mitral valve prolapse	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Palpitations	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart murmur	Y <input type="checkbox"/> N <input type="checkbox"/>	Coronary heart disease	Y <input type="checkbox"/> N <input type="checkbox"/>	High blood pressure	Y <input type="checkbox"/> N <input type="checkbox"/>
Arrhythmia	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Failure	Y <input type="checkbox"/> N <input type="checkbox"/>	Low blood pressure	Y <input type="checkbox"/> N <input type="checkbox"/>
Rheumatic heart disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Implanted defibrillator	Y <input type="checkbox"/> N <input type="checkbox"/>	Swelling of the ankles	Y <input type="checkbox"/> N <input type="checkbox"/>
Infective endocarditis	Y <input type="checkbox"/> N <input type="checkbox"/>	Pacemaker	Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep on many pillows	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial heart valves	Y <input type="checkbox"/> N <input type="checkbox"/>	Arteriosclerosis	Y <input type="checkbox"/> N <input type="checkbox"/>		

Respiratory / Lung Problems?

Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Pneumonia	Y <input type="checkbox"/> N <input type="checkbox"/>	Snoring	Y <input type="checkbox"/> N <input type="checkbox"/>
Bronchitis	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinusitis	Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea	Y <input type="checkbox"/> N <input type="checkbox"/>
Emphysema/COPD	Y <input type="checkbox"/> N <input type="checkbox"/>	Persistent cough	Y <input type="checkbox"/> N <input type="checkbox"/>	Sarcoidosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>				

Diabetes/Endocrine Disorder?

Diabetes Type 1	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypothyroidism	Y <input type="checkbox"/> N <input type="checkbox"/>	Adrenal gland disorder	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes Type 2	Y <input type="checkbox"/> N <input type="checkbox"/>	Hyperthyroidism	Y <input type="checkbox"/> N <input type="checkbox"/>		

Kidney/Urogenital Disorder?

Kidney stones	Y <input type="checkbox"/> N <input type="checkbox"/>	Renal failure/Insufficiency	Y <input type="checkbox"/> N <input type="checkbox"/>	Dialysis	Y <input type="checkbox"/> N <input type="checkbox"/>
Frequent Urination	Y <input type="checkbox"/> N <input type="checkbox"/>				

Cancer or Tumors?

Malignant	Y <input type="checkbox"/> N <input type="checkbox"/>	Benign	Y <input type="checkbox"/> N <input type="checkbox"/>
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Neurologic / Nerve Problem?

Stroke	Y <input type="checkbox"/> N <input type="checkbox"/>	Feelings of depression	Y <input type="checkbox"/> N <input type="checkbox"/>	Seizures/epilepsy	Y <input type="checkbox"/> N <input type="checkbox"/>
Transient Ischemic Attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Feelings of anxiety	Y <input type="checkbox"/> N <input type="checkbox"/>	Neuropathies	Y <input type="checkbox"/> N <input type="checkbox"/>
Fainting or dizzy spells	Y <input type="checkbox"/> N <input type="checkbox"/>	PTSD	Y <input type="checkbox"/> N <input type="checkbox"/>	Multiple Sclerosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Feeling of numbness	Y <input type="checkbox"/> N <input type="checkbox"/>	Mental health disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Parkinson's disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Weakness	Y <input type="checkbox"/> N <input type="checkbox"/>	Obsessive/compulsive dis.	Y <input type="checkbox"/> N <input type="checkbox"/>	ADD/ADHD	Y <input type="checkbox"/> N <input type="checkbox"/>
Headache	Y <input type="checkbox"/> N <input type="checkbox"/>	Dementia/Alzheimer's	Y <input type="checkbox"/> N <input type="checkbox"/>		

Blood / Hematologic Disorder?

Anemia	Y <input type="checkbox"/> N <input type="checkbox"/>	Deep vein thrombosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Multiple myeloma	Y <input type="checkbox"/> N <input type="checkbox"/>
Bleeding disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Sickle cell disease/trait	Y <input type="checkbox"/> N <input type="checkbox"/>	Leukemia	Y <input type="checkbox"/> N <input type="checkbox"/>
Bruise easily	Y <input type="checkbox"/> N <input type="checkbox"/>	Thalassemia	Y <input type="checkbox"/> N <input type="checkbox"/>	Lymphoma	Y <input type="checkbox"/> N <input type="checkbox"/>

Gastrointestinal (GI) Disorder?

Acid reflux(GERD)	Y <input type="checkbox"/> N <input type="checkbox"/>	Irritable bowel syndrome	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/>
Heart burn	Y <input type="checkbox"/> N <input type="checkbox"/>	Crohn's disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Cirrhosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Ulcers	Y <input type="checkbox"/> N <input type="checkbox"/>	Gall stones	Y <input type="checkbox"/> N <input type="checkbox"/>	Jaundice	Y <input type="checkbox"/> N <input type="checkbox"/>

Musculoskeletal / Connective tissue Disorder?

Arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Gout	Y <input type="checkbox"/> N <input type="checkbox"/>	Fibromyalgia	Y <input type="checkbox"/> N <input type="checkbox"/>
Osteoporosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Lupus	Y <input type="checkbox"/> N <input type="checkbox"/>	Sclerodema	Y <input type="checkbox"/> N <input type="checkbox"/>
Joint replacement	Y <input type="checkbox"/> N <input type="checkbox"/>	TMJ disorder	Y <input type="checkbox"/> N <input type="checkbox"/>		

Infectious Disease?

HIV	Y <input type="checkbox"/> N <input type="checkbox"/>	STD	Y <input type="checkbox"/> N <input type="checkbox"/>	Cold sores	Y <input type="checkbox"/> N <input type="checkbox"/>
AIDS	Y <input type="checkbox"/> N <input type="checkbox"/>	MRSA	Y <input type="checkbox"/> N <input type="checkbox"/>	Mononucleosis	Y <input type="checkbox"/> N <input type="checkbox"/>

Staff Initials: _____ Patient Name: _____ INTAKE 8

Head / Eye / Ear / Nose / Throat Problem?

Vision problems

Y ☐N ☐

Glaucoma

Y ☐N ☐

Hearing impairment

Y ☐N ☐

Wearing contact lenses

Y ☐N ☐

Cataract

Y ☐N ☐**Dermatologic / Skin Problem?**

Psoriasis (dry skin)

Y ☐N ☐**CURRENT MEDICATIONS:** Please list all medications you are taking (prescribed, over the counter, supplements).

Name of Medication	Dosage (mg/ml)	Frequency	Date Started	Prescribed By
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please indicate your Preferred Pharmacy we may use for prescriptions:

Pharmacy:

Address:

Phone:

Fax:

Please list any current Medical Diagnoses:

1.

Date Diagnosed:

2.

Date Diagnosed:

3.

Date Diagnosed:

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Digital Signature:

Date:

☐***PROVIDERS ONLY:** As a provider, I have reviewed pages 6, 7, and 8 of this patient's intake form.

Provider's Printed Name: _____

Provider's Signature: _____ Date: _____

Staff Initials: _____ Patient Name: _____ INTAKE 9