LANTERN MEDICAL CLINIC

INTAKE FORM

General Information:

Name _____
First *Middle Initial* *Last*

Date of Birth _____

Age _____ Gender o *Male* o *Female*

Address_____
Street Number *Apt. #*

_____
City *State* *Zip Code*

Home Phone _____ Cell Phone _____

E-mail Address _____

Emergency Contact Name _____ Phone #_____

Employment: *(We may call for income verification)*

_____
Where Employed *Supervisor's Name*

_____
Work Phone #

Insurance:

Do you carry any medical insurance? _____
Do you qualify for Medicare or Medicaid? _____

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Personal Medical History:

Name _____ Date of Birth _____

Regular Doctor's Name _____

Dr.'s Address _____ Phone #_____

Which pharmacy do you use? _____

Current Medications _____

_____

Medication Allergies _____

Food Allergies _____

Other Allergies_____

Previous Illnesses and Dates _____

_____

_____

Previous Surgeries and Dates _____

_____

_____