Milwaukie Wellness Center Intake Form

PLEASE PRINT CLEARLY **Date:_____**

First Name_____ Mid._____ Last_____

Address_____ City_____ State_____ Zip_____

Work Phone _____ Home Phone _____ Cell_____

Primary Language: English / Spanish / Other_____ Race/Ethnicity:_____

Social Security #: _____-_____-_____ Birthdate_____ Age_____

Employer_____ Address_____

Marital Status_____ Spouses Name:_____

Nearest Relative Not Living With You?_____ Relationship?_____

Emergency Contact_____ Phone Number_____

BRIEFLY DESCRIBE YOUR SYMPTOMS:_____
_____
_____

PREVIOUS TREATMENT, FILMS FOR THIS CONDITION?_____
_____
_____

PLEASE LIST YOUR MEDICAL HISTORY INCLUDING:
FRACTURES/DISLOCATIONS_____ WHEN?_____
SURGERIES:_____ WHEN?_____
CANCER:_____ WHEN?_____
OTHER:_____
LIST YOUR CURRENT MEDICATIONS:_____

I understand that as a courtesy to me this office will bill, when appropriate, my insurance company directly. I still remain financially responsible for all charges. I instruct my insurance company to pay this office directly for all services and authorize the release of any information necessary to secure payment. I hereby authorize the doctor and the designated assistants, to administer treatment as deemed necessary and also authorize the release of any information acquired in the course of my examination or treatment as per the HIPPA authorization and limitations. I certify that the above information is true and correct.

If you are not the insured please note the nature of your relationship to the insured?
Spouse / Child / Domestic Partner / Other_____

Would You Like to Be On Our Email List? (We send periodic updates on special offers and events)
Email Address:_____

Patients or Guardians Signature_____