

Medical Record Form Sample - New Patient Intake

This **medical record form sample** is designed to streamline the new patient intake process by capturing essential personal and health information efficiently. It ensures accuracy and completeness, facilitating better patient care and record-keeping. Using this standardized form helps healthcare providers maintain organized and accessible medical histories.

Patient Information			
Full Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Gender:	<input type="text" value="Select"/> <input type="button" value="▼"/>	Phone:	<input type="text"/>
Email:	<input type="text"/>	Preferred Contact Method:	<input type="text" value="Email"/> <input type="button" value="▼"/>
Address:	<input type="text"/>		
Emergency Contact			
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Phone:	<input type="text"/>	Alternate Phone:	<input type="text"/>
Insurance Information			
Insurance Provider:	<input type="text"/>	Policy Number:	<input type="text"/>
Group Number:	<input type="text"/>	Subscriber Name:	<input type="text"/>
Medical History			
Primary Physician:	<input type="text"/>		
Current Medications:	<input type="text"/>		
Allergies:	<input type="text"/>		
Past Surgeries/Hospitalizations:	<input type="text"/>		
Chronic Health Issues:	<input type="text"/>		
Family Medical History:	<input type="text"/>		
<i>Please list any other concerns or information you would like your provider to know:</i> <input type="text"/>			

Consent and Signature

I certify that the above information is accurate and complete to the best of my knowledge. I consent to the medical examination and treatment as deemed necessary by my healthcare provider.

Patient Signature: _____ Date: _____

Submit

