PCOM Georgia

Georgia Osteopathic Care Center

Patient Intake Form

Patient Information

Last Name _____ First Name _____ Date of Birth _____

Sex _____ Race _____ Marital Status _____ Preferred Language _____

Address _____ City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____ Email Address _____

Preferred method of contact: Cell phone ____ Home phone____ Email _____ Ok to leave a message? YES / NO

Occupation _____ Place of Employment _____

Preferred Pharmacy - name, location, phone number _____

Emergency Contact Information

Name _____ Home Phone _____ Cell Phone _____

Relationship to Patient _____

If Patient is a Minor:

Name of Responsible Party _____ Relationship to Child _____

If the child is living with one parent, is it okay to give information to the other parent? YES / NO

Parent's Information

Mother's Name _____ Date of Birth _____ Phone _____

Father's Name _____ Date of Birth _____ Phone _____

Insurance Information:

Insurance Company _____ Member ID _____

Group ID _____ Name of Policy Holder _____ Policy Holder D.O.B. _____

How did you hear about us? _____

Referred by: _____

Patient Signature _____ **Today's Date** _____