



HARBOR POINTE

PRIMARY CARE

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Legal first name

Last name

Preferred name

Date of birth (MM/DD/YYYY)

Pronouns (optional)

Street address

City

State

ZIP code

Phone number

Email address

Preferred contact method:

☐ Phone

☐ Text

☐ Email

EMERGENCY CONTACT

Name

Relationship

Phone number

INSURANCE INFORMATION

Primary insurance company

Member ID

Group number (if applicable)

Policyholder name (if different)

Please bring your insurance card(s), photo ID, and current medication list.

Information provided will be used for registration and care coordination.



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MEDICAL HISTORY

Reason for today's visit / main concerns:

Current medical conditions / past diagnoses:

Past surgeries / hospitalizations:

MEDICATIONS & ALLERGIES

Current medications (name, dose, frequency; attach list if needed):

Medication or other allergies and reactions:

☐ No known drug allergies

HEALTH & SOCIAL HISTORY

☐ Tobacco use ☐ Alcohol use ☐ Recreational drug use

Relevant family medical history:

PATIENT ACKNOWLEDGMENT

I confirm that the information above is accurate to the best of my knowledge.

Patient / guardian signature

Date
