Patient Update Forms

Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male ○ Transgender ○ Non-binary
○ Other

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. Please attach a copy of your photo ID

3. Preferred Language:

○ English ○ Hindi ○ Spanish
○ Gujarati ○ Punjabi ○ Other

If other, please specify:

_____

4. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, please specify:

_____

5. Ethnicity:

☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a)

6. How did you learn about this office? _____ Who referred you? _____

7. Emergency Contact: Relationship:

Address: City, State & Zip:

Phone: Alt. Phone:

8. Previous Primary Doctor: Phone:

Other Health Provider: Phone:

Preferred Pharmacy (name and address): Phone:

9. Is it ok to leave a detailed message on your home or mobile phone number listed?

○ Yes ○ No

10. At Onestop Medical Clinic, we communicate regularly with patients via phone, email, and/or text messages regarding things like appointment confirmations and health maintenance. Please provide consent to communications you would like to receive.

Communication Method	I consent to:	I do not consent to:
Text Messages	Yes	No
Phone Calls	Yes	No
Emails	Yes	No

11. Would you like us to be able to discuss your medical condition(s) (including diagnosis, results, treatments, and care received) with a member(s) of your family?

○ Yes ○ No

12. Please list individuals (and relationship) with whom you allow us to share your health information:

	First and Last Name	Relationship
1)		
2)		
3)		

13. Do you have Medical Insurance?

○ Yes ○ No

14. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Do you have secondary insurance?
○ Yes ○ No

15. Please upload a copy of the front and back of your primary insurance card

16. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

17. Please upload a copy of the front and back of your secondary insurance card

18. I authorize the release of any medical information necessary to process my claim and payment of benefits.

Authorization to bill insurance

Signature | Date