Vitality Natural Health and Wellness Center

"The path to a healthier, more vital you."

PATIENT INTAKE FORM

Today's Date: _____

Name: _____
(Last, First, Middle Initial)

Date of Birth: _____ Sex: Male / Female
(Month/Day/Year)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____Cell Phone: (____)_____Work Phone: (____)_____

May we leave confidential messages for you at any of the above numbers? Yes / No (Specify): ❍ Home ❍ Work ❍ Cell

Email Address: _____ May we contact you by email? Yes / No

Primary Care Physician: _____ Physician's Phone: (____)_____

Physician's Address: _____City: _____ State: _____ Zip Code: _____

Employer: _____Occupation: _____

Work Address: _____City: _____ State: _____ Zip Code: _____

Marital Status (Please circle one): Single Married Separated Divorced With Partner Widow

Name of Spouse (or parent/guardian if a minor): _____

Whom may we contact in case of an emergency: _____

Relationship to you: _____ Emergency Contact #: (____)_____

How did you hear of us? (Please circle one):
Yellow Pages Newspaper Radio/TV Internet Sign/Flyer Informational Talk Word of Mouth Other: _____

Were you referred by another patient? Yes / No Were you referred by a physician? Yes / No

If you answered "yes" to either of the above questions would you provide us with as much information as possible so that we may thank them for referring you to us at Vitality Natural Health and Wellness Center.

Referring Patient/Physician's Name: _____
Address, City, State, Zip: _____
Phone Number: _____

_____ _____ _____
Patient's Signature Parent/Guardian's Signature Date

For Office Use Only: ☐ Address Entered ☐ Email Entered ☐ Referral Thank You/ Credit (if applicable)

570 Washington Street
Meadville, PA 16335

www.vitalityhealthandwellness.com

Phone: 814-720-4825
Fax: 814-601-0930