ANODYNE
PAIN & WELLNESS SOLUTIONS

	DATE	TIME
APPT DATE		
DATA BASE		

☐PAPERWORK EMAILED TO PATIENT
☐SCANNED TO INSURANCE - CM

NEW PATIENT INTAKE REACTIVATION INTAKE

LEGAL NAME:_____DOB:_____|_____|_____

PREFERRED NAME:_____MARITAL STATUS: single/married/widowed/ divorced

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____
verbal consent to send paperwork via email { } Yes { } No

HOW DID YOU HEAR ABOUT US? PATIENT REFERRAL _____, EMPLOYEE REFERRAL_____

RADIO, TENTACLE, SEMINAR, INSURANCE, GOOGLE, FACEBOOK, ZOCDOC, EVENT, OUTSIDE PROVIDER _____

OTHER: _____

_____

WHAT IS YOUR MAJOR HEALTH CONCERN? _____

WHEN DID IT START? _____Pain Scale:1 2 3 4 5 6 7 8 9 10 (1 least pain -10 most pain)

ADDITIONAL NOTES:_____

What treatment have you received for this condition and when: _____

Have you been injured? AUTO ACCIDENT ON THE JOB Date: _____

REACTIVATIONS: over 3 months: re-exams | 12 months +: new intake/re-exam | 3 yrs +: new intake/exam

Reason for Returning: { } Resume care
{ } New Condition Please describe: _____
{ } Flare Up of Old Condition Please describe: _____
{ } Pain Scale Please circle one: 1 2 3 4 5 6 7 8 9 10 (1 least pain and 10 most pain)

PRIMARY
Insurance Company: _____
_____
Type of Insurance (Circle) HMO PPO

ID #: _____
_____
Group #: _____
_____
Phone #: _____
_____
Policy Holder's Name: _____
_____
DOB: _____
_____

SECONDARY
Insurance Company: _____
_____
Type of Insurance (Circle) HMO PPO

ID #: _____
_____
Group #: _____
_____
Phone #: _____
_____
Policy Holder's Name: _____
_____
DOB: _____
_____