# *Welcome to Anesthesiology Professionals*

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call

(913) 339-9437 or at our Toll Free 1 -866-611-8851 if you have any questions or are unsure how to complete any section of this form.

## New Patient Intake Paperwork

**Patient Information**

Today's Date _____

Your Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ lbs

Street Address: _____

City/State/Zip: _____

Email: _____ Gender: ❑ Male ❑ Female

Physical Address Same as Mailing? ❑ Yes ❑ No If not, please list mailing address: _____

_____

_____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____ Driver's License # / State: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other _____

## Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

## Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

## Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

## Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone number: _____ Fax number: _____

Claim Number: _____ Date of initial injury: _____

## Injury Claim

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (Legal term describing injury sustained to your person by negligence of another) ❑ Yes ❑ No If yes, you will be asked to complete a separate form

I certify that the above information is accurate, complete and true. I give my consent for **Anesthesiology Professionals** to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: _____ Date: _____