Polk's Crossgates Discount Drugs
Patient Intake Form

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Patient SSN: ______________________________

Patient Address: ______________________________

Patient Billing Address: ______________________________

Patient Primary Phone Number: ______________________________

Patient Secondary Phone Number: ______________________________

Patient Email Address: ______________________________

Patient Primary Insurance:

Plan Name: ____________ **Member ID:** ____________ **Group:** ____________

Patient Secondary Insurance:

Plan Name: ____________ **Member ID:** ____________ **Group:** ____________

Patient Tertiary Insurance:

Plan Name: ____________ **Member ID:** ____________ **Group:** ____________

Patient Medical/Emergency Proxy if Applicable

Proxy Name: ______________________________

Proxy Address: ______________________________

Proxy Phone: ______________________________

Proxy Email: ______________________________

Patient Medical History (list below):

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Patient Primary Doctor: ____________________ **Doctor Phone:** ____________

Patient Secondary Doctor: ____________________ **Doctor Phone:** ____________

Patient Signature: ____________________ **Date:** ____________

If Medical Proxy Signing

Medical Proxy Signature: ____________________ **Date:** ____________