Dr. Angela Reiter & ASSOCIATES

Intake Form

Name of Patient:_____

Name of Parent (Legal Guardian, if applicable):_____

Address:_____

City_____ **State**_____ **Zip Code**_____

Telephone:_____ **(H)** _____**(C)**

Date of Birth:_____ **Age:**_____ **Gender: Male/Female**

Email Address:_____

Marital Status:_____

Emergency Contact:_____

(Name) (Telephone)

Employed: Yes/No Occupation:_____

Name of Employer:_____

Name of Primary Insurance Company:_____

Policy Number/Member ID:_____ **Group (if any)**_____

Name of Primary Insured:_____ **Date of Birth:**_____

Primary Insured's Relationship to patient:_____