ROOTED HEALTH
Holistic Healing

INTAKE FORM

PATIENT INFORMATION

Patient's Name :
(PLEASE USE CAPITAL)
Date of Birth:

Address : _____ **Gender** : ☐ Male ☐ Female
: _____

Phone Number : _____ **SSN** : _____

POA : _____ **POA Phone Number** : _____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Schedule Contact : _____ **Relation to Patient:** _____

PRIMARY CARE PHYSICIAN

Name/Number : _____

INSURANCE (PLEASE PROVIDE COPY)

Primary : _____ **Member ID** : _____

Secondary : _____ **Member ID** : _____

WOUND ETIOLOGY

Date : _____ **Type of Wound/Location** : _____

How it Occurred? : _____ **Related Conditions?** : _____

Has wound been treated? (If so provide documentation) : _____ **Staff Signature** : _____

More Information :
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945-213-2828 (Office)
www.rootedhhh.com

THANK YOU