Catherine Screnci MD PLLC **Today's Date: _______________**

PATIENT INTAKE FORM

Patients under 18- Parent must complete **Patients over 18- Patient must complete**

Last Name: _______________________________ **First Name: ______________________________**

Date of Birth: _____________________________ **Sex:** Male □ Female □

Primary Language: _______________________

Ethnicity: Hispanic □ Non-Hispanic □ Other: ____

Race: American Indian/Alaskan Native □ Asian □ Black or African-American □

White □ Hawaiian Native/Pacific Islander □ Decline to specify □

Primary Address: ____

City/Town: ________________________ State: ___________________ Zip Code: _______________

Primary Phone of Parent: ___________________ Patient Cell Phone: _______________________

Current Medications:

____

____

Current Medical Problems:

____

____

Allergies and Reactions:

____

____

I authorize payment of my child’s medical benefits to their PCP:

Signature: ____

Primary Care Physician (Please check ONE): Catherine Screnci □ Argyro Karidis □

Insurance Carrier: ____

Guarantor: ___________________________________ Relation to Patient: ______________________

Patients over 18:

Patient email: ____

Do you give your parent/guardian permission to access your health records? Yes □ No □

Signature: ____