CLYNIX BIOMED TESTING & TELEMEDICINE

General Patient Intake Form

Patient Demographics

Full Legal Name:	_____
Date of Birth:	_____
Sex at Birth:	_____
Phone Number:	_____
Email Address:	_____

Home Address (Required for Telemedicine)

Street Address:	_____				
City:	_____	State:	____	ZIP:	_____

Emergency Contact

Name:	_____	Phone:	_____

Telemedicine Location Confirmation

I confirm that I am physically located in the following state at the time of my telemedicine visit: _____

Preferred Pharmacy

Pharmacy Name:	_____
Pharmacy Address:	_____
Pharmacy Phone:	_____

Insurance & Payment Selection

■ I will use insurance ■ I am a self-pay / cash-pay patient

Insurance Carrier:	_____		
Member ID:	_____	Group #:	_____

Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient Signature:	_____	Date:	_____