Temp:
BP:
O2:
HGT:
WGH:
H/R:

HOMETOWN
CONCIERGE HEALTH
in-home family medicine

Patient Intake Form

Date: ___________________

PATIENT NAME (LAST FIRST MI): ___________________________________

NICKNAME: _______________________________

Date of Birth: ___________________ Cell Phone#: ___________________

ADDRESS: ____

Gender: Male Female Married: Yes No Children: Yes No

E-MAIL ADDRESS TO BE USED TO CONTACT YOU WITH TEST RESULTS

: ____

Emergency Contact Name:______________________________________ Phone #:____________________

Relationship to Patient: _______________________________

Patient Signature____ Date____________________ OR

Guardian Signature____ Date_____________________

CONSENT FOR VENIPUNCTURE (Blood Draw)

General Consent to Care:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to venipuncture, as ordered by a provider, provided through Hometown Concierge Health on an outpatient visit basis. This consent includes my consent for all medical services rendered including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care professionals under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Hometown Concierge Health is not liable for common complications with venipuncture.

Patient Signature____ Date____________________ OR

Guardian Signature____ Date_____________________