Bloom Functional Medicine
Functional Med. Intake Form

Name:_____Date of birth:_____

Preferred e-mail:_____

Would you like to placed on waiting list for:

____Dr. Worden ____Dr. Bowman ____Either Dr. Worden or Dr. Bowman

For what condition (s) or symptom (s) are you wanting to see functional medicine practitioner?

Who is your Primary Care Provider (PCP)? _____

Have you been referred to our clinic?_____Yes ____No

If yes, who has referred you?_____

Do you require a referral by your insurance company?_____Yes ____No

Do you have a family member that is seen at Bloom Functional Medicine?____Yes ____No

If yes, what is their name and relation to you _____

If you will be using medical insurance to pay for visit, what insurance do you have?

Insurance name:_____Plan name: _____

Have you checked with insurance to see if we are in network? ____Yes ____No

You can find a list of plans we are in network with on our website:
https://bloom-functional-medicine.com/insurance

Thank you for providing the above information. We will reach out to you soon to complete the new patient registration process.