Bloom Functional Medicine
PCP Intake Form

Name:___________________________________Date of birth:_______________

Preferred e-mail:____

For what condition(s) or symptom(s) are you wanting to see Dr. Meigs, our primary care practitioner?

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.