APhA
AMERICAN PHARMACISTS ASSOCIATION
Improving medication use. Advancing patient care.

Example Patient Intake Form for Medication Administration Services

Patient Information

Patient Name

First Name____________________ Middle Initial_____________Last Name________________________

Sex/gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Date of Birth _______/_______ /_______

Street ____

City ____State____________Zip _______________

Home Phone ____

Work Phone___________________________________Mobile Phone _____________________________

Email Address ____

Patient's Employer ____

Occupation ____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____________________

Race: ☐ White ☐ Black/African-American ☐ Hispanic/Latino ☐ Asian/Pacific American
☐ Native American ☐ Other:__________________________

Emergency Contact

Name____

Relationship to Patient ____

Home Phone ____

Work Phone___________________________________Mobile Phone _____________________________

Primary Insurance

Insured's Name

First Name____________________ Middle Initial_____________Last Name________________________

Relationship to Patient ____

Insured's Date of Birth _______/_______ /_______

Insured's Address (if different from patient's)

Street ______________________________

City ______________________ State __________ Zip __________

Insured's Phone Number ______________________________

Insured's Employer ______________________________

Insured's Occupation ______________________________

Insurance Plan Name ______________________________

Insurance Policy/ID Number ______________ Insurance Group Number __________

Insurance Company Phone Number ______________________________

Secondary Insurance

Is this patient covered by additional insurance? ☐ Yes ☐ No

Insured's Name

First Name __________ Middle Initial __________ Last Name __________

Insured's Relationship to Patient ______________________________

Insured's Date of Birth ______/______ /______

Insured's Address (if different from patient's)

Street ______________________________

City ______________________ State __________ Zip __________

Insured's Phone Number ______________________________

Insured's Employer ______________________________

Insured's Occupation ______________________________

Insurance Plan Name ______________________________

Insurance Policy/ID Number ______________ Insurance Group Number __________

Insurance Company Phone Number ______________________________

General Practitioner

Physician Name ______________________________

Address

Street ______________________________

City ______________________ State __________ Zip __________

Phone Number ______________ Fax Number ______________