Andrews Institute for Addiction Treatment, LLC
4402 Peach St., Suite 4; Erie, PA 16509
Phone: 814-616-0075; Fax: 814-281-5956
www.addictionmedicinedoc.com

PATIENT INTAKE FORM – ALL INFORMATION IS CONFIDENTIAL

Name: _____ Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Age: _____

Phone (with area code):

Cell: (_____) _____ VM message OK? □ Yes □ No Preferred number? □ Yes □ No

Home: (_____) _____ VM message OK? □ Yes □ No Preferred number? □ Yes □ No

Office: (_____) _____ VM message OK? □ Yes □ No Preferred number? □ Yes □ No

E-mail: _____ OK to reach you by e-mail (including sending bills/receipts)? □ Yes □ No

Insurance Carrier: _____

Person financially responsible for your treatment (if other than you):

Name: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ E-mail: _____

Emergency Contact:

Name: _____ Relationship to you: _____

Phone: (_____) _____

Primary care physician/provider: _____ Phone: (_____) _____

Referred? _____

Psychiatrist / Therapist: _____ Phone: (____) _____

Other specialists involved in your care:

Name: _____ Specialty type: _____

Phone: _____ Referred? _____

Name: _____ Specialty type: _____

Phone: _____ Referred? _____

Name: _____ Specialty type: _____

Phone: _____ Referred? _____