Patient Intake Form # 1 A - Progressive Child & Adolescence Gastroenterology (PCAG)

Demographics:

Patient's Name: _____ DOB: _____

Gender: Male: ❑ Female: ❑ Other: ❑ _____

Parent/Guardian's Name: _____Relationship to patient:_____

Phone: _____ Email: _____

Address: _____City: _____State:_____Zip:_____

Emergency Contact name and phone: _____

Referred By:

Primary Care Doctor: _____Phone_____Fax_____

Referring Doctor: _____Phone_____Fax_____

Online Source: _____ ER: _____ Other: _____

Pharmacy:

Pharmacy Name: _____

Address: _____

Phone: _____Fax_____

Insurance:

Insurance Company: _____ Type: ❑PPO ❑HMO

ID: _____ Group #: _____

Subscriber Name: _____ Relationship to patient_____

Address if different: _____DOB: _____

Insurance Referral needed: YES: ❑ NO: ❑ _____

Secondary Insurance: YES: ❑ NO: ❑ _____

If yes, ID: _____ Group #: _____

Parent/Guardian Information If different from above:

Name: _____ Date of Birth: _____

Gender: M F Marital Status: S M W D

Address, City, State, Zip: _____

Phone #: _____ Driver's License # _____

Signature of Parent/Guardian_____ Date _____

Revised 03/10/2025