iNetMed Rx² Inc.

Date:		Name of Person completing the form:					
Patient	Last Name:		First Name			DOB	
	Cell Phone Number:	Marital Status: Single Married Partnered Divorced Separated Other:_____					
	Home Address:						
	City		State	Zip Code		Female ☐	Male ☐
	Emergency Contact:				Relationship:		
	Emergency Contact Phone Number:						

Referral Source: ☐ SELF ☐PRIMARY CARE PHYSICIAN ☐ CYFD* ☐COURT ORDERED* OTHER: _____

*** IF REFERRED BY CYFD OR COURT ORDER, WHO IS YOUR WORKER?: _____ PH NO: _____**

Minor Child	Parent/ Guardian - Last Name		First Name			DOB	
	Cell Phone Number:	Marital Status: Single Married Partnered Divorced Separated Other:_____					
	Home Address:					Female ☐	Male ☐
	City		State		Zip Code	Relationship:	
	Parent/ Guardian - Last Name		First Name			DOB	
	Cell Phone Number:	Marital Status: Single Married Partnered Divorced Separated Other:_____					
	Home Address					Female ☐	Male ☐
	City		State	Zip Code		Relationship:	

Primary Care Physician:	Address	Phone

Insurance	Primary Insurance	Member Name	
	Member ID Number	Member DOB	SSN
	Group Number	Member Phone	Care Coordinator:
	Secondary Insurance	Member Name	
	Member ID Number	Member DOB	SSN
	Group Number	Member Phone	

Patient/Parent Signature:	Date:
Staff Signature:	Date:

I understand that I will be charged a fee of $90.00 for any appointments rescheduled or cancelled without a 24 hour notice. After two no showed appointments, the patient will be transferred back to the referring or primary care provider.

PLEASE INITIAL: _____ Date: _____