

New Patient Intake Form

Please print clearly. All information is HIPAA-protected and confidential.
(210) 876-1635 | primevitalitycare.com | San Antonio, TX

1 Personal Information

First Name *

Last Name *

Date of Birth *

Sex Assigned at Birth *

Preferred Pronouns

Phone Number *

Email Address *

Street Address *

City *

State *

ZIP Code *

Emergency Contact Name

Emergency Contact Phone

How did you hear about us?

Referred by (name)

2 Insurance Information

Insurance Provider

Plan / Group Number

Member / Subscriber ID

Primary Policy Holder

If self-pay or no insurance, leave blank. We offer financing through PatientFi (0% up to 9mo), Wurthy, and CareCredit.

3 Medical History

Current Medical Conditions (check all that apply):

Diabetes

High Blood Pressure

Heart Disease

Thyroid Disorder

Autoimmune Disorder

Depression / Anxiety

Asthma / COPD

Cancer History

Hormone Imbalance

Chronic Pain

Gut / Digestive Issues

Obesity / Weight Issues

Other conditions

Section 3 continued...

Previous Surgeries (with approximate dates)

Known Allergies (medications, food, latex, etc.)

Family Medical History

4 Current Medications & Supplements

Prescription Medications (name — dosage — frequency)

Over-the-Counter Medications

Vitamins, Supplements & Herbs

5 Lifestyle & Health Goals

What brings you to Prime Vitality Care today? *

Services you're interested in (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight Loss / GLP-1 | <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Peptide Therapy |
| <input type="checkbox"/> Functional Medicine | <input type="checkbox"/> IV Therapy | <input type="checkbox"/> Aesthetics (Face) |
| <input type="checkbox"/> Aesthetics (Body) | <input type="checkbox"/> Hair Restoration | <input type="checkbox"/> Sexual Health |
| <input type="checkbox"/> Telehealth | <input type="checkbox"/> Concierge / Membership | |

Exercise Frequency

Avg Sleep (hrs/night)

Stress Level (1-10)

Tobacco / Nicotine Use

Alcohol Use

Anything else you'd like Dr. Goel to know?

6 Consent & Acknowledgment

By signing below, I acknowledge and agree:

- The information provided is accurate and complete to the best of my knowledge.
- I authorize Prime Vitality Care to use this information for diagnosis and treatment.
- My health information is protected under HIPAA and will be kept confidential.
- I consent to receiving communications regarding my care and appointments.
- I am financially responsible for services not covered by insurance.

Patient Signature (print full legal name) *

Date *

How to Submit This Form

Option 1: Fill online at primevitalitycare.com/patient-hub/ | Option 2: Email to drshivgoel@primevitalitywellness.com
Option 3: Bring completed form to your first appointment | Option 4: Fax to (210) 876-1635