**A logo for a medical group

Description automatically generated**

**Patient Intake Form**

**Please answer the following questions so you chart can be updated.**

**1.Preferred name (what would you like to be called):**

**2. E-mail address to have on file:**

**3. Preferred to way to be contacted:** PHONE or TEXT

**4. Marital Status:**

MARRIED DIVORCED PARTNER SINGLE WIDOWED LEGALLY SEPARTED UNKNOWN

**5. Race:**

**6. Ethnicity:**

**7. Primary Language:**

**8. Are you a United States Veteran?**  YES or NO **If yes, which branch:**

**9.Employement Status:**

FULL-TIME PART-TIME RETIRED SELF-EMPLOYED NOT-EMPLOYED ACTIVE-DUTY STUDENT

**10. Living Arrangements:**

PERMANENT RESIDENT SEASON RESIDENT MIGRANT HOMELESS

**11. Sex:**  MALE or FEMALE

**12. Do you have a Power of Attorney – Healthcare\*\*?**  YES or NO

**13. Do you have a DNR (Do Not Resuscitate) \*\*?**  YES or NO

**\*\*If you have answered yes to any of these options, we need these on file.**

**You may drop them off at the front desk or:**

**You may fax any :** POA/DNR/DNI to: 309-762-5519

**You may e-mail:** [**Medicalrecords@amgqc.com**](mailto:Medicalrecords@amgqc.com)