PATIENT INTAKE FORM
RANCHO MEMORY CLINIC
Rancho Los Amigos/USC

MRN#
CADC#
E-CONSULT STAMP

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	MOTHER'S MAIDEN NAME	FATHER'S FULL NAME

BIRTHDATE	AGE	SEX	BIRTH PLACE	RACE	PREFERED LANGUAGE

LEGAL STATUS	SOCIAL SECURITY #	EDUCATION YEARS
CITIZEN ☐ RESIDENT ☐ UNDOCUMENTED ☐		

MARITAL STATUS	FULL NAME OF SPOUSE	HANDEDNESS
		RIGHT ☐ LEFT ☐

PRIMARY PHYSICIAN

PHYSICIAN NAME	ADDRESS/CITY/STATE	PHONE

ALLERGIES	IF YES
YES ☐ NO ☐	

INSURANCE

MEDI-CAL #	ISSUE DATE:
MEDICARE #	ISSUE DATE: A: B:
PRIVATE INSURANCE: ______________________ ADDRESS: ______________________ PHONE#:	ID#: ______________________ GROUP #: ______________________ ISSUE DATE:

CONTACT INFORMATION

PERSON TO CONTACT	RELATIONSHIP	PREFERED LANGUAGE
E-MAIL	PREFERRED PHONE # H C W	ALT PHONE # H C W

ADDRESS OF CONTACT	CITY	STATE	ZIP

REFERRED BY:

☐ ALZ ASSOC ☐ ONLINE RESEARCH ☐ PHYSICIAN: ______________________

☐ OTHER:

COMMENT ____