Client Intake Form

Amega Prestige Health – Client Intake & Registration
*Date: _____
*Referred By (if any): _____

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1. Client Information (Required)
Full Name: _____
Date of Birth: ____ / ____ / _____
Gender: ☐ Male ☐ Female ☐ Other: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____
Email: _____

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2. Emergency Contact (Optional)
Name: _____
Relationship: _____
Phone: _____

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3. Health History (Required)
Please check any that apply:
☐ Diabetes
☐ High Blood Pressure
☐ Heart Condition
☐ Fainting/Dizziness with blood draws
☐ Blood clotting disorder (Hemophilia, etc.)
☐ On blood thinners (e.g., Coumadin, Plavix, Aspirin)
☐ Seizure disorder
☐ Other: _____
*Allergies (medications, latex, adhesive tape, etc.):

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*Current Medications (list or attach sheet):

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4. Specimen Collection History (Required)
Have you ever had difficulty with blood draws? ☐ Yes ☐ No
Do you have a preferred arm/hand? ☐ Left ☐ Right
Any history of fainting during lab draws? ☐ Yes ☐ No

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5. Insurance / Payment Information (if applicable)
Primary Insurance Provider: _____
Policy Number: _____
Group Number: _____
Subscriber Name (if not self): _____
☐ I will be paying out of pocket.
☐ I will be seeking insurance reimbursement.

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6. Service Authorization (Required)
☐ I authorize Amega Prestige Health to collect specimens and, when required, share necessary health information with the designated laboratory for testing purposes.
☐ I acknowledge that I have reviewed and signed the Consent to Services & Liability Waiver and the HIPAA Notice of Privacy Practices.

Client Name (Print): _____
Signature: _____
Date: _____
Provider/Witness: _____