One Smarter Health
REMOTE SECOND OPINION/E-CONSULT/PATHOLOGY

PATIENT INTAKE FORM

First Name: _____ M.I.: _____ Last Name: _____

PERSONAL INFORMATION (REQUIRED)

Date of Birth: ____ / ____ / _____ Social Security Number: _____ - ____ - _____

Mother's Maiden Name: _____ Father's Name: _____

CONTACT INFORMATION (REQUIRED)

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Is it okay to contact you at work: Yes/No

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Email: _____

MEDICAL QUESTIONS (REQUIRED)

What is your diagnosis/disease/disorder in question? _____
_____

What explicit questions do you want answered within the remote second opinion?
_____
_____
_____
_____
_____

What do you hope to gain by engaging the services of a remote second opinion?
_____
_____
_____
_____