Eden Spa Orlando Patient Intake Form

eden
Comfort the body. Renew the soul.

Appointment Date: _____

Appointment Time: _____

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:_____ Birthdate:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Social Security Number:_____ Patient Employer:_____

Employer Address:_____ Work Phone:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Guarantor Information:

Primary Insurance Holder:_____ DOB:_____ SSN:_____

Employer:_____ Holder's Phone Number:_____

Insurance:

Primary Insurance:_____ Group Number:_____ I.D. Number:_____

Address:_____ Provider Phone Number:_____ Fax Number:_____

Secondary Insurance:_____ Group Number:_____ I.D. Number:_____

Address:_____ Provider Phone Number:_____ Fax Number:_____

Emergency Contact Information:

Name:_____ Relationship:_____ Phone Number:_____

Cell Phone Number:_____

Prescription Information:

Referring Physician:_____ Phone Number:_____ Fax Number:_____

Primary Care Physician:_____ Phone Number:_____ Fax Number:_____

Diagnosis:_____ Items Needed:_____

Patient has script ☐ or ☐ **Please bring prescription to your appointment.**

Email completed form to fh.EdenSpaOrlando@flhosp.org or Fax to (407) 303-3257