Improving Chances
Dr. J. Chance Ortego, M.D., M.P.H.
Patient Intake Form

Name (Last, First MI): ____

Address:______________________
City: _________________________
State: ________________________
Zip:__________________________

Primary Phone Number:____________________ Date of Birth (MM/DD/YYYY): _________

Is it okay to leave a message for you from us? Yes / No
Is it okay to email you? Yes / No

Emergency Contact:
Name: _______________________________
Relationship to patient: ___________________
Contact number: _________________________

Past Medical/Psychiatric Information:
Have you ever been diagnosed with a psychiatric condition (depression, anxiety), and if so which one(s)?
____

Current medications:
____

Allergies:
____

Have you had any thoughts of wanting to harm yourself or others in the last 2 weeks? Yes / No

Improving Chances, LLC
Dr. J. Chance Ortego, M.D., M.P.H.
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Record Release Authorization

I hereby authorize J. Chance Ortego, M.D. and Improving Chances, LLC to furnish information to insurance carriers concerning this treatment.

Name: Signature: Date:

Consent to Treatment

I hereby agree to be treated by J. Chance Ortego, M.D. and Improving Chances, LLC. I agree that I am personally responsible for ensuring that all charges for services rendered are paid.

Name: Signature: Date:

Consent to Payment for Professional Services

Credit/Debit Card Information: VISA Mastercard American Express Discover

Name as it appears on card: ___________________________________
Credit/Debit card Number: _____________________________________
Security Code: ____
Expiration Date: ____
Billing Zip Code: ____

I/we authorize Improving Chances, LLC to bill the above credit / debit card for professional services

as outlined in the Office Policies. I will notify J. Chance Ortego, MD, in writing if I no longer want my credit / debit card billed.

Name:___________________________ Signature: _________________________ Date: ________ 2