

New Client Intake Form

Please complete and submit this form upon booking. Email completed forms to: Info@Ratana.care
If you have any questions please contact us at (818)-644-7716.

General Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

E-mail: _____

Address: _____

Today's Date: _____

Date & Time of Surgery: _____

Planned Surgery & Surgery Center: _____

Height and weight: _____

How did you hear about Ratana? _____

Emergency Contacts

Name & Relationship: _____

Phone Number: _____

Medical History

Previous Surgeries: _____

Previous Illnesses: _____

Current Medical Conditions: _____

Current Medications, including dosages: _____

Preferred Pharmacy Name &Phone Number: _____

Do you have any allergies to medications? _____

Do you have any other allergies? _____

Social History

Marital Status:_____

Do you own any pets? If so, what kind and how many?

Occupation:_____

Do you use caffeine? If so, how much & how often? _____

Do you use tobacco? If so, how much & how often? _____

Do you use alcohol? If so, how much & how often? _____

What are your biggest fears/worries regarding your upcoming surgery?

Other things you think we should know?

Thank you for taking the time to complete this form. Please e-mail your completed form to
Info@Ratana.care.