Bloom Functional Medicine -Dr. Worden
Functional Medicine Intake Form

Name: _____ Date of birth:_____

Who is your Primary Care Provider (PCP)? _____

Have you been referred to Dr. Worden? ____Yes ____No

*If yes, who referred you?*_____

Do you have a family member that is seen by Dr. Worden ? ____Yes ____No

If yes, what is their name and relation to you _____

For what condition (s) are you wanting to see a functional medicine practitioner?

If you will be using medical insurance to pay for your visits, what insurance do you have?

Insurance name: _____

Plan name: _____

Do you require a referral by your insurance company? Yes ____ No____

Have you checked with your insurance to see if we are in-network?[1] Yes ____ No____

Have you read about the BFM Membership Plan on the website, and do you understand that Dr. Worden is only accepting new patients who will be joining the BFM Membership Plan?[2] Yes ___ No___

Thank you for providing the above information.
Please keep an eye out for emails from us regarding the New Patient Process and BFM Membership info

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[1] *You can find a list of plans we are in-network with on our website:* https://bloom-functional-medicine.com/insurance

[2] *You can find more information about the BFM Membership program on our website:* https://www.bloom-functional-medicine.com/copy-of-about