Intake Form Demographic Information

First Name: ____

Middle Initial: ____

Last Name: ____

Date of Birth: ____

Social Security Number (Optional): ____

Sex: M F

Marital Status:____

Address: ____
City:____

State: ____

Zip Code: ____

Phone Number: ____

Email Address: ____

Referring Physician Name (Optional): ____

Referring Physician Phone Number & NPI (Optional) : __________________________

Insurance Information Primary Insurance Company:

____

Subscriber ID # (including letters): ____

Group Number: ____

Secondary Insurance Company: ____

Subscriber ID # (including letters): ____

Group Number: ____

Insurance Policyholder Full Name: ____

Insurance Policyholder Date of Birth: ____

Insurance Policyholder Address: ____

Insurance Policyholder Relationship: Self Spouse Child Other Insurance Policyholder

Social Security Number: _______________________________

Insurance Policyholder Sex: M F * Note: All information is required.

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: ______________________________________ Date: __________

Guardian Signature (if minor): ______________________________ Date: __________

Patient Full Name: ____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: ______________________________________ Date: __________

Guardian Signature (if minor): _____________________________ Date: __________

Patient Full Name: ____

* Note: All signatures are required.