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INTAKE SHEET

Date: _____ Referred By: _____

Name of Patient: _____

Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Employer: _____

Email: _____ May use my email for appt. reminders: ☐

Marital Status: Single ☐ Married ☐

Name of Partner/Spouse: _____

Date of Birth: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Insurance Information:

I will not be using insurance ☐

Insurance Carrier: **(Primary Insurance):** _____

Claims Submission Address: _____

Group #: _____ Subscriber I.D. #: _____

Name of Policy Holder: _____ Birthdate: _____

Insurance Carrier: **(Secondary Insurance):** _____

Claims Submission Address: _____

Group #: _____ Subscriber I.D. #: _____

Name of Policy Holder: _____ Birthdate: _____

Responsible Billing Party *if other than Patient*:

Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

I agree to allow the use and disclosure of my health information for treatment, billing and payment. If I have health insurance, I also authorize payment of insurance medical benefits to my physician.

Signature: _____ ***Date***: _____