PATIENT INTAKE FORM

First: **MI:** **Last:**

Date of Birth: **Age:** **Birth Sex:** Male ☐ Female ☐

Mailing Address: ____________________
____
____

Physical Address: ____________________
____
____
____

OK To Call	**Phone Number:**	**Best Time To Call:**
☐	Home:	
☐	Work:	
☐	Cell:	

SSN:

Height: **Weight:**

Race:

☐ **American Indian / Alaska Native** ☐ **Asian** ☐ **Black or African American**
☐ **Native Hawaiian / Other Pacific Islander** ☐ **White**

Ethnicity:

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Preferred language:

Interpreter required? ☐

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Unknown**

Student Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **None**

Provider: **Phone:**
Billing Ref: **Phone:**

EMPLOYMENT STATUS

Employment Status:
☐ **Active Military** ☐ **Full-Time** ☐ **None** ☐ **Part-Time** ☐ **Retired** ☐ **Self Employed**

Employer:	Occupation:
Address:	
Phone:	

Employer:	Occupation:
Address:	
Phone:	

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name:	Holder's Birth Date:
Policy or Certificate #:	Group #:
Policy Holder's Employer:	

Secondary Insurance:

Policy Holder's Name:	Holder's Birth Date:
Policy or Certificate #:	Group #:
Policy Holder's Employer:	

Please Note: We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement regarding a disputed claim. Payment for the office charge is expected at the time services are rendered.

Note: Please provide us with the most updated information down below.

CONTACTS

Name	Phone	Work	Cell	Fax	Type

ALLERGIES

Date	Status	Type	Allergen	Severity	Reaction	Source

MEDICATIONS

Medication	Dose	Dose Unit	Freq	Admin

How did you hear about us?

❑ **Adjustor**	❑ **Newspaper**	❑ **Sports**
❑ **Attorney**	❑ **Parent**	❑ **Spouse**
❑ **Billboard**	❑ **Patient**	❑ **Staff**
❑ **Case Manager**	❑ **Primary Care Physician**	❑ **Surgeon**
❑ **Email**	❑ **Radio**	❑ **Television**
❑ **Friend**	❑ **Referring Doctor**	❑ **Walk-In**
❑ **Guardian**	❑ **Relative**	❑ **Website/Internet**
❑ **Listing**	❑ **Specialist**	❑ **Other Contact**
		❑ **Other Referral**

If other, please specify: ____

Primary Email Address: ____
May we contact you at this email address? ❑**Yes** ❑**NO**

Therapy Consent and Insurance Authorization

Please initial each line below before signing.

_______ I hereby consent to therapy services and authorize the administration of all procedures.

_______ I hereby authorize this clinic to release or obtain any information which may be necessary to determine benefits payable under the above stated plans as described in the notice of privacy practices for protected health information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_______ Acknowledgement of receipt "NOTICE OF PRIVACY PRACTICES": I have received, or was offered and declined, a copy of "Notice of Privacy Practices."

_______ YES __NO ___ I hereby assign insurance benefits to this clinic.

_______ I certify the above noted Insurance carriers or payment sources are complete and correct as written. I understand that the patient or I, as responsible party, may be liable for services not covered by above noted insurance carriers.

____
Patient Name *(Please print)*

______________________________ ______________________
Signature **Date**