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INTAKE INFORMATION

Patient name_____ Date_____
Last First Middle
Street Address_____
City_____ State_____ Zip_____
Date of birth_____Marital Status____
Home/cell phone_____(may I leave a message?) Work phone_____

Occupation_____Employer_____
Employer Address_____
Spouse, Parent or Next of Kin_____Phone_____
Emergency Contact_____Phone_____
(may I have your permission to contact this person in a perceived life or death emergency?) yes/ no Signature_____

Referred by_____May I have your permission to thank this person for their referral? yes/no

HEALTH INSURANCE

Primary_____Policy#_____
Group#_____
Policy Holders's name_____ date of birth_____
Social Security#_____
Address for claims_____

Secondary_____Policy#_____
Group#_____
Policy Holders's name_____ date of birth_____
Social Security#_____
Address for claims_____

I understand that I am financially responsible for all charges whether or not paid by my insurance company. Assistance will be provided in filing claims, but insurance difficulties are not the doctor's responsibility. Appointment time is reserved. Cancellation must be made 24 hours in advance to avoid being charged the full fee, which will not be paid by insurance. I authorize release of information necessary for treatment and processing of insurance claims to the insurance company, the doctor's billing service and the doctor.

_____ _____
Patient's signature date