**Provider Name, Licenses**
Provider Address, Provider Phone

# 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

**Provider Name, Licenses**
Provider Address, Provider Phone

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.*

## Credit Card On File

Credit Card Full Name: _____

Credit Card Number: _____

Expiration Date: _____/_____ Security Code (3 Digits for Visa, 4 Digits for AMEX): _____