Patient Intake Form

Name _____ SS# _____-_____-_____ Date of Birth _____
Address _____ City_____ State_____ Zip Code _____
Home # _____ Work # _____ Cell # _____

Employer Name_____ Occupation _____
Address _____ City _____ State _____ Zip Code _____
Person to Contact in Case of Emergency _____
Relationship_____ Phone Number _____

Referring Physician _____ Diagnosis _____
Address _____ Phone #_____

Name of Insured/ Policy Holder _____ SS#_____-_____-_____ DOB _____
Address_____ Phone #_____
Employer Name _____ Relationship to Patient_____

Primary:
Insurance Company _____
Address _____ City_____ State _____ Zip Code _____
Phone #_____ Policy/ ID # _____ Group/ Claim # _____
Claim Adjuster _____ Date of Injury_____
Secondary:
Insurance Company _____
Address _____ City _____ State_____ Zip Code _____
Phone #_____ Policy/ ID # _____ Group/ Claim #_____

I hereby give authorization for payment of insurance benefit to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all the charges not paid by my insurance company. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s).

_____ _____
Signed Date