Patient Intake Form

Patient Information

First Name: MI:
Last Name:
Address:
City: St. Zip:

Home Phone: ( ) -
Work Phone: ( ) -
Birth Date: / /
Sex: Male Female
Soc. Sec. # - -

Responsible Party (if other than patient)

Name:
Address:
City: St. Zip:

Home Phone: ( ) -
Work Phone: ( ) -
Sex: Male Female

(If there are two responsible parties please fill out ANOTHER Intake Form and write "Second Responsible Party" on the top of the form)

General Insurance Information

Marital Status:
- Single
- Married
- Other

Employment Status:
- Employed
- Full Time Student
- Part Time Student

Patient's Condition Related to:
- Employment?: Yes No
- Auto Accident?: Yes No Which State:
- Other Accident?: Yes No

Insurance Company Information

Ins. Co. Name:
Address:
City: St: Zip:

ID Number:
Policy Number:
Group Number:

Policy Holder

First Name: MI:
Last Name:
Address:
City: St: Zip:

Home Phone: ( ) -
Work Phone: ( ) -
Birth Date: / /
Sex: Male Female

Status (Champus Claims): Active Duty Retired Deceased Other
What is your relationship to the insured?: Spouse Child Self Other_____
Are you under your employer's Health Plan?: Yes No
Employer's Name:
Insurance Plan Name:
Is your signature on file?: Yes No

(If there is another Health Benefit Plan, please fill out another Intake Form and write "Secondary Insurer" on the top of the form)