Intake Date

Name Age

Gender

Birthdate City/State/Country of Birth Address City zip code

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell, Work or Home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different: City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/State \_\_\_\_Zip\_\_\_\_\_\_\_

Parent/legal guardian #1 (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_State\_\_\_ Zip \_\_\_\_\_\_\_\_

Parent/legal guardian #2 (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_State\_\_\_ Zip \_\_\_\_\_\_\_\_

Emergency Contact

Relationship Phone

Address City State\_\_\_\_\_\_\_

Daytime Phone Evening phone

# INSURANCE INFORMATION (if you want me to bill your insurance company for you)

Insurance Company:

Billing Address City/State Zip

Name of Subscriber Subscriber Birth date \_\_\_\_\_\_\_\_\_

Subscriber address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_ zip\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID# Group #

Co-pay: \_\_\_\_\_\_\_\_\_\_\_ Yearly deductible: \_\_\_\_\_\_\_\_\_Current Amnt met? \_\_\_\_\_\_ Month deductible resets: \_\_\_\_\_\_\_\_

**Current Personal Physician:**  Phone Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_

**Medications (list all) Dosage (amount and times per day) Reason**

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