INTAKE FORM

PATIENT INFORMATION

Last name *

First Name *

MI

Address *

Address

Address 2

City

State / Province / Region

ZIP / Postal Code

Home Phone *

Patient Employer

Work Phone

Birth Date *

SS# *

Gender *

Gender*

Cell Phone

Pharmacy Phone

RESPONSIBLE PARTY INFORMATION

Last Name

First Name

MI

Address

Street

City

State / Province / Region

ZIP / Postal Code

Birth Date

SS#

Employer

Employer Address

City

State

Work Phone

Relationship To Patient

INSURANCE COMPANY INFORMATION

Primary

Insured's Name

Ins Company

SS#

Birth Date

Employer

Phone

ID number

Group

Secondary

Insured's Name

Ins Company

SS#

Birth Date

Employer

Phone

ID number

Group

I have completed this form accurately and completely. I certify that I am the patient or the legal representative of the patient. I understand that full payment is due at the time of treatment, unless arrangements are made otherwise. I agree to pay any amount not covered by insurance. I authorize the release of any information necessary to process insurance claims.

Medicare Only: My signature requests that payment be made to physician. I am responsible for deductible, coinsurance and non-covered services only.

Date