CLIENT INTAKE FORM

(Please Print)

Today’s Date \_\_\_/\_\_\_/\_\_\_\_

Home Phone No.

( )

Client’s Last Name Name Middle

\_\_\_\_ Mr.

\_\_\_\_ Ms.

Marital Status (Circle One) Single / Married / Other

CLIENT INFORMATION

SECONDARY INSURANCE INFORMATION (if applicable)

Client’s Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number

Ins. ID number

Birth Date

\_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_

Social Sec #

 - -

Insured’s Name

( ) Self Pay

EAP Authorization Number (if applicable):

( ) Blue Cross/ Blue Shield ( ) Aetna

( ) Cigna ( ) Cigna EAP ( ) Aetna EAP

*If your insurance company is not listed, you will be expected to pay in full.*

**Please Select Your Primary Insurance Provider**

Work Phone No.

( )

Employer Address

Employer

Occupation

Email Address:

Cell Phone No.

( )

Home Phone No.

( )

Address (if different)

Birth Date

\_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_

Person Responsible for Bill

INSURANCE INFORMATION

Alternative Email Address:

Email Address: (used for appointment reminders)

Referred to Provider by (Please check one box & list) ( ) Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Insurance

( ) Family ( ) Friend ( ) Internet ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone No.

( )

Employer

Alternative Address City State Zip

Cell Phone No.

( )

 Social Security

 - -

Street Address City State Zip

Age

Sex

\_\_\_M \_\_\_F

Birth Date

\_\_\_/\_\_\_/\_\_\_\_\_

(Former Name)

If not, what is your legal name?

Is this your legal name?

\_\_\_Yes \_\_\_No

Occupation

Cell Phone

Cell Phone

Home Phone

Home Phone

Relationship

Relationship

Name of Local Friend or Relative (not living at same address)

Name of Local Friend or Relative (not living at same address)

IN CASE OF EMERGENCY

Client’s Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #

Insurance ID #

Name of Secondary Insurance

Insured’s Name