INTAKE INFORMATION FORM:

Date: _____

NOTE: If Not Applicable, Please Type N/A In The Field.

How did you hear about us?				
Where are you from?				
Do you have insurance? Which one?				
PATIENT INFORMATION			Primary Care Physician:	
Last Name:			Date of Birth:	
First Name:		MI:	MALE ◯ FEMALE ◯	
Address:			Social Security Number:	
City:	State:	ZIP:	Employer:	Availability:
Home Phone:	2nd Phone:		Email:	
Do you feel you have a problem with alcohol? How much on average do you drink? Do you feel you have a problem with drugs? What is the dose of the medication and how often taken? What type of medication/street drugs do you take?			What problems are you experiencing currently? Do you feel the impulse to harm yourself or others? Have you been upset for more than 7 days? Have you had Prior Treatment? Where and When?	
What brings you to the office?			Is Transportation going to be an issue?	

Insurance Information: Primary

Insured Name:	Relationship to Patient:		DOB:
Insurance Company:			
Insurance Company Address:			
City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:

Insurance Information: Secondary

Insured Name:	Relationship to Patient:		DOB:
Insurance Company:			
Insurance Company Address:			
City:	State:	ZIP:	Phone:
Policy No:	Group No:		Employer:

Notes:

Check off (initial next to task):

_____ Background Check _____ OARRES _____ Pre-Auth _____ Create Chart

_____ Enter Marketing Information in Spreadsheet

_____ Scan Intake form into New Patient Documents in EMR