INTAKE FORM – Adult Patient

YOUR NAME

WHO REFERRED YOU TO ME?

GENDER ☐ MALE ☐ FEMALE MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ P

DATE OF BIRTH SSN

HOME ADDRESS

CITY, STATE, ZIP

E-MAIL ADDRESS MAY WE E-MAIL YOU? YES ☐ NO ☐

EMPLOYER OCCUPATION

HOME PHONE _____

MAY WE CALL? YES ☐ NO ☐ LEAVE A MESSAGE? YES ☐ NO ☐

WORK PHONE _____

MAY WE CALL? YES ☐ NO ☐ LEAVE A MESSAGE? YES ☐ NO ☐

CELL PHONE _____

MAY WE CALL? YES ☐ NO ☐ LEAVE A MESSAGE? YES ☐ NO ☐

SPOUSE

DATE OF BIRTH SSN

EMPLOYER OCCUPATION

WHO IS RESPONSIBLE FOR PAYING YOUR BILL? _____

(IF OTHER THAN YOU, FILL OUT BELOW AND HAVE RESPONSIBLE PARTY SIGN THIS FORM.)

RELATIONSHIP TO YOU SSN

ADDRESS IF DIFFERENT

CITY, STATE, ZIP

EMPLOYER OCCUPATION

WORK PHONE HOME PHONE

PRIMARY INSURANCE COMPANY NAME

ADDRESS/PO BOX

CITY, STATE, ZIP

INSURANCE PHONE

MENTAL HEALTH PHONE

POLICY HOLDER 'S NAME

ID #

GROUP #

GROUP NAME

POLICY HOLDER'S EMPLOYER

YOUR RELATIONSHIP TO POLICY HOLDER

☐ SELF
☐ SPOUSE
☐ PARTNER
☐ CHILD
☐ OTHER

IF POLICY HOLDER IS OTHER THAN YOU, FILL OUT BELOW

SSN DOB

STREET ADDRESS

CITY, STATE, ZIP

HOME PHONE

WORK PHONE

CELL PHONE

E-MAIL ADDRESS

2NDARY INSURANCE COMPANY NAME

ADDRESS/PO BOX

CITY, STATE, ZIP

INSURANCE PHONE

MENTAL HEALTH PHONE

POLICY HOLDER 'S NAME

ID #

GROUP #

GROUP NAME

POLICY HOLDER'S EMPLOYER

YOUR RELATIONSHIP TO POLICY HOLDER

☐ SELF
☐ SPOUSE
☐ PARTNER
☐ CHILD
☐ OTHER

IF POLICY HOLDER IS OTHER THAN YOU, FILL OUT BELOW

SSN DOB

STREET ADDRESS

CITY, STATE, ZIP

HOME PHONE

WORK PHONE

CELL PHONE

E-MAIL ADDRESS

FOR OFFICE USE DX USUAL PROCEDURE CODE USUAL POS USUAL FEE

- I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided by Dr Johannsen. This release of information expires December 31, 2014.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Johannsen. I request payment of government benefits either to myself or to the party who accepts assignment.
- I understand that I am fully responsible for all professional fees not covered by this assignment of insurance benefits.
- I understand that payment in full is due at the time of service unless prohibited by Dr Johannsen's contract with my insurer.

_____

Responsible Party's Signature Date