❖ Intake Form ❖

NAME

WHO REFERRED YOU TO ME?

DATE OF BIRTH | GENDER | SOCIAL SECURITY #

AGE | MARITAL STATUS

HOME ADDRESS

CITY, STATE, ZIP CODE

E-MAIL ADDRESS — MAY WE E-MAIL? Yes No

YOUR EMPLOYER

YOUR OCCUPATION — YEARS OF EDUCATION

YOUR HOME PHONE — MAY WE CALL? Yes No — LEAVE A MESSAGE? Yes No

YOUR WORK PHONE — MAY WE CALL? Yes No — LEAVE A MESSAGE? Yes No

YOUR CELL PHONE — MAY WE CALL? Yes No — LEAVE A MESSAGE? Yes No

RESPONSIBLE PARTY — RELATIONSHIP TO PATIENT

ADDRESS IF DIFFERENT — SOCIAL SECURITY #

HOME PHONE IF DIFFERENT — WORK PHONE

EMPLOYED BY

SPOUSE PARTNER | DOB | SPOUSE'S EMPLOYER

NAME | SOCIAL SECURITY #

OTHERS LIVING IN YOUR HOME: NAME — BIRTH DATE — RELATIONSHIP TO YOU

EMERGENCY CONTACT NAME — RELATIONSHIP TO YOU — PHONE

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE CO NAME		INSURANCE CO NAME	
STREET ADDRESS/PO BOX		STREET ADDRESS/PO BOX	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
INSURANCE CO PHONE		INSURANCE CO PHONE	
NAME OF INSURED	RELATIONSHIP TO INSURED	NAME OF INSURED	RELATIONSHIP TO INSURED
ID# OF INSURED	SELF	ID# OF INSURED	SELF
GROUP #	SPOUSE	GROUP #	SPOUSE
GROUP NAME	PARTNER	GROUP NAME	PARTNER
DATE OF BIRTH OF INSURED	CHILD	DATE OF BIRTH OF INSURED	CHILD
ADDRESS AND PHONE OF INSURED (IF DIFFERENT)		ADDRESS AND PHONE OF INSURED (IF DIFFERENT)	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
HOME PHONE		HOME PHONE	
WORK PHONE		WORK PHONE	
CELL PHONE		CELL PHONE	

FOR OFFICE USE ONLY — DX — USUAL PROC 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 Clifford A. Johannsen, Ph.D. This release of information expires December 31, 2014.
- I authorize my insurance company to pay medical benefits to the provider of services, Clifford A. Johannsen, Ph.D. 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.
- I understand that payment in full is due at the time of service unless prohibited by Clifford Johannsen's contract with my insurer.

Signature **Date**

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