INSURANCE INTAKE FORM

PERSONAL

Last Name: _____ First Name: _____

Street Address _____ Apt _____

City _____ State _____ Zip _____

Phone Number: _____ work / home / cell

Email: _____

DOB: _____ Gender: Male / Female

Status: Married / Single / Other

Chief Complaint (*what condition(s) you would like to work on*): _____

Employment Status: Employed / Full-Time Student / Part-Time Student

Employer's Name: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____ work / home / cell

INSURANCE

Carrier Name: _____ example: United Healthcare

Plan Name: _____ example: Choice Plus & PPO/POS/HMO

Phone # (*eligibility dept*): _____

Patient's Relationship to Insured: Self / Spouse / Child / Other

Member ID#: _____

Group / Account #: _____

Payer ID#: _____

POLICYHOLDER (*Only complete if the patient is not the policyholder primary on insurance*):

Last Name: _____ First Name: _____

Street Address _____

City _____ State _____ Zip _____

Phone Number: _____ work / home / cell

Email: _____

DOB: _____ Gender: Male / Female

Employer's Name: _____