

# Client Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Marital status:  Single  Married

Children's Names and Ages: \_\_\_\_\_

Name of Spouse/Significant Other: \_\_\_\_\_

Preferred Appointment Day and Time: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_

Time and Date of Insurance Verification: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

Provider's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_

Permission to Consult with Primary Provider?  No  Yes \_\_\_\_\_ (please initial if yes)

In Case of Emergency, Please Notify:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

\*Please note that if you are billing insurance companies, your clients will have to fill out a claim form (most likely a HCFA-1500) that duplicates most of this information.