

Patient Intake Form

Today's Date: Appointment Da	ate:	11me:	□AM □ PM
Previous Patient: □Yes □No			
Patient Name (Last, First, Middle)			DOB//
Social Security:/	Sex: □Male [□Female	
Home Address:			
Home PhV	Vk Ph	(Cell Ph
Email Address:	Emplo	oyer Name:	
Emergency Contact:	Phone	e Number:	
Relationship to Patient: Spouse Par	ent 🗆 Sibling	☐ Other	
	Insurance In	nformation	
Type of Plan: □ HMO □ PPO □ Medica	re Medicaid		
Primary Insurance:		Pol#	Grp#
Subscriber Name:	DOB:	:/ SS	SN:
	naa Dadu	ctible:	Met? ☐ Yes ☐ No Amount M
Eff Date:/ Copay/Coinsura	ince Dedu	CHOIC	
•			
Referring Physician Name:	1	Primary Care Ph	
Referring Physician Name:Office#/ Fax#Additional Information Ins Main Number:	Office to be completed by Auth Phone:	Primary Care Phye#/Fax#y Paradigm The	ysician:erapy PartnersExt:
Referring Physician Name: Office#/ Fax# Additional Information Ins Main Number: Secondary Insurance:	Office to be completed by Auth Phone: Pol #	Primary Care Ph	ysician:
Referring Physician Name: Office#/ Fax# Additional Information Ins Main Number: Secondary Insurance: Subscriber Name:	to be completed by Auth Phone: Pol # DOB:	Primary Care Ph	erapy PartnersExt: Grp# SN:
Referring Physician Name: Office#/ Fax# Additional Information Ins Main Number: Secondary Insurance: Subscriber Name: Eff Date:// Copay/Coinsura	to be completed by Auth Phone: Pol # DOB:	Primary Care Ph	erapy PartnersExt: Grp# SN:
Referring Physician Name: Office#/ Fax# Additional Information Ins Main Number: Secondary Insurance: Subscriber Name: Eff Date:// Copay/Coinsura Max Visits:(Per condition/Per Cal y	to be completed by Auth Phone: Pol # DOB: nce Deduction of the property of the	Primary Care Phye#/Fax# y Paradigm The :// SS ct:	Partners Ext: Grp# SN: Met? Y/N Amount Met:
Referring Physician Name: Office#/ Fax#	to be completed by Auth Phone: Pol # DOB: nce Deduct PCP I	Primary Care Phye#/Fax# y Paradigm The :// SS ct: Ref Needed: Y/N	Partners Ext: E
Referring Physician Name: Office#/ Fax# Additional Information Ins Main Number: Secondary Insurance: Subscriber Name: Copay/Coinsura Max Visits: (Per condition/Per Cal y Auth/Per-Cert#	to be completed by Auth Phone: Pol # DOB: nce Deduct r) PCP I #Visits Confirmation N	Primary Care Phye#/Fax# y Paradigm The :// SS ct: Ref Needed: Y/N Claim Address	erapy PartnersExt: Grp# SN: Met? Y/N Amount Met: N Auth-Cart Needed: Y/N ess:
Referring Physician Name: Office#/ Fax#	to be completed by Auth Phone: Pol # DOB: nce Deduct PCP I #Visits Confirmation N Authorization	Primary Care Phye#/Fax#	erapy PartnersExt: Grp# SN: Met? Y/N Amount Met: N Auth-Cart Needed: Y/N ess:
Eff Date:// Copay/Coinsura Referring Physician Name: Office#/ Fax#	to be completed by Auth Phone: Pol # DOB: nce Deduct r) PCP I #Visits Confirmation NAuthorization r) PCP Ref Neede	Primary Care Phye#/Fax# y Paradigm The :// SS ct: Ref Needed: Y/N Claim Addre Jumber: Phone: ed: Y/N	erapy PartnersExt: Ext: Grp# Met? Y/N Amount Met: Auth-Cart Needed: Y/N ess: Ext: Ext:

Office: (240) 479-6769

Fax: (888) 242-8040