Patient Intake

In Ntwk *Out of Ntwk*

Date: ____________________

Patient Name: ______________________________ D.O.B.: ____________________

Insurance Carrier: ______________________________ Ins. Phone: ____________________

Emergency: ______________________________ ID/Claim #: ____________________

Type: *Symptoms Began / Date of Accident:* ____________________

Patient Information Chief Complaint: ____________________ Male Female

Full Address ____

Phone ________________________ Email ____

Marital Status: *Employment Status:* *Relationship to Insured:*

Insured Information Ins. ID #: ____________________ Male Female

Name: ____ D.O.B: ____________

Full Address: ____

Plan Information Group: ____________________ Plan: ______________________

Calendar / Plan Year: Calendar Plan *Effective:* ____________________

Claims Address: ____

Sub to: ____ Payer ID: ____________

Deductible IN: __________________________ OUT: __________________________

	Acupuncture	Office Visit	Physical Therapy
Covered @ **IN/**			
OUT/			
Copay/Co-Ins: **IN/**			
OUT/			
Yearly Max / Used			
Combined with:			

Notes: ____

Ref #: ______________________________ Carrier Rep: ____________________