billingline

(Select the text tool then place your cursor in the field to type in your information, then you can use the tab key between fields to complete. Then "Click to Print" at the bottom, or print first and fill out by hand.)

Intake Form

DX: _____

Provider Name: _____

Initial Appointment Date: _____

Patient Name: _____ DOB: _____

Patient Phone: _____ Gender: ☐ Male ☐ Female OK to leave message?: ☐ Y ☐ N

_____

Patient Address: _____

_____

Insurance Company: _____

Insurance ID #: _____

Subscriber Name: _____ DOB: _____
(if different from above)

Provider in Network?: ☐ Y ☐ N

Insurance Contact: _____

Authorization required?: ☐ Y ☐ N Authorization #: _____

# of Sessions: _____ Co-pay: _____ Deductible: _____

Other Notes: _____

Intake Date: _____ Authorization Date: _____

Click to Print

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