

In  
Ntwk

Out of  
Ntwk

### Patient Intake

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

Patient Name: _____	D.O.B.: _____
Insurance Carrier: _____	Ins. Phone: _____
Emergency: _____	ID/Claim #: _____

Type: \_\_\_\_\_ Symptoms Began / Date of Accident: \_\_\_\_\_

<b>Patient Information</b>	Chief Complaint: _____	Male	Female
Full Address _____			
Phone _____	Email _____		
Marital Status: _____	Employment Status: _____	Relationship to Insured: _____	

<b>Insured Information</b>	Ins. ID #: _____	Male	Female
Name: _____	D.O.B: _____		
Full Address: _____			

<b>Plan Information</b>	Group: _____	Plan: _____
Calendar / Plan Year: _____	Calendar	Plan
Claims Address: _____	Effective: _____	
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: \_\_\_\_\_