Date: _____ ***New Patient Intake Form***

Patient Name: _____ Age: _____ DOB: _____
Parent Name: _____
Address: _____
_____
Who referred you: _____ Phone:_____
Parent/Patient Email Address: _____
Home Phone: _____ Cell Phone:_____
Language Preference _____
Appointment Date: _____ Time: _____.

Marital Status: _____ Custody Type: ☐Legal ☐Physical %_____

Other parent's contact info: _____

Presenting Problem: _____
_____
_____.
Notes: _____
_____
_____.

Financial Responsibility

☐ Insurance ☐ Fee for Service $ _____ Rate/ Session

Insurance Carrier: _____ Mental Health Carve out _____
Main Subscriber Name: _____ D.O.B: _____
Subscriber/Member # _____ SS#_____
Provider Line: _____

Outpatient Mental Health Benefits

Effective Date: _____
Ind. Deductible: _____ How much has been applied _____.
Authorization: _____ Co-Pay: _____.

Benefit Details:
_____
_____
_____

Claims Address: _____
_____.
Reference #:_____

Patient/Guardian Signature: _____ Date: _____