Physician Name ________________________
Address _____________________________
____
Phone # (   ) _____ - ________
Fax # (   ) _____ - __________

Telephone Intake

PATIENTS NAME:_______________________________ SEX: ____ MALE _____FEMALE

AGE:______ DOB:_____________

PARENTS STATUS: SINGLE_______ MARRIED_______ DIVORCED______

MOTHER:______________________________ PHONE:__________________________

ADDRESS:______________________________ CELL:____________________________

______________________________ WORK:___________________________

FATHER:______________________________ PHONE:___________________________

ADDRESS:_____________________________ CELL:____________________________

______________________________ WORK:___________________________

TYPE OF INSURANCE:____
(*WE DON'T TAKE HEALTHY OPTIONS/MOLINA/BASIC HEALTH PLAN)**

ADVISE TO CONTACT INSURANCE COMPANY: YES ________ NO________

SUBSCRIBER: _______________________ SSN: ________________ DOB: ____________

REASON FOR EVALUATION:

____

____

____

REFERRED TO:_________________________ BY:_______________________

DATE:_________________________________