CONFIDENTIAL INTAKE FORM

Patient Information

Name: ______________________________ Date: ______________

Address: ______________________________ City: ______________ State: _____ Zip: ___________

Home Phone: ______________ Work Phone: ______________ Cell: ______________

Email: ______________ Birth Date: __________ Age: _____ Male: _____Female:_____

Occupation/Activities: ______________________________

In case of emergency, please contact: ______________ Phone: __________ Relationship: __________

Employer: ______________ How did you learn about us? ______________

Injury Treatment? Yes ____ No ____ Date of Injury: __________ Auto: ____ Work: ____ Other: _____

Referring Physician: ______________________________ Phone: ______________

Fax: ______________ Location: ______________________________

Insurance Information

Primary Health Insurance: ______________________________

ID #: ______________________________ Group #: ______________________________

Insured/Policy Holder Name: ______________________________ Birth Date: ______________

Insured Social Security #: ______________ Relationship to Insured: Self: _____ Spouse: _____ Child: ______

Insurance Company Address: ______________________________ Phone: ______________

Secondary Ins. (if applicable): ______________________________

ID #: ______________________________ Group #: ______________________________

Insured/Policy Holder Name: ______________________________ Birth Date: ______________

Insured Social Security #: ______________ Relationship to Insured: Self: _____ Spouse: _____ Child: ______

Insurance Company Address: ______________________________ Phone: ______________

Auto Insurance: ______________ or **L & I/ Worker's Comp**: ______________

Claim #: ______________ Claims Adjuster: ______________ Phone: ______________

Auto Insurance Address: ______________________________ Phone: ______________

PLEASE READ AND SIGN BELOW

Payment is due at the time of service. Once your insurance coverage has been verified, I can bill the insurance company directly and accept payment from them. It should be understood that all services are charged to you, the client, who is legally responsible for payment.

I authorize the release of my information to be used for medical and/or insurance billing purposes. I have signed the "Notice of Privacy Practices" form.

Missed appointments, or cancelled with less than 24 hours notice, will be billed at standard rate. Circumstances will be considered.

I understand my massage practitioner does not diagnose illness or disease, or prescribe treatments. I have stated all known medical conditions in "Health History" form and agree to inform the massage practitioner of any changes in my physical or mental health.

______________________________ ______________

Guardian or Patient Signature Date