|  |  |
| --- | --- |
| **Patient’s Name:** |  |
| **DOB:** |  |
| **Street Line:** |  |
| **Street Line2:** |  |
| **City:** |  |
| **State:** |  |
| **Zip:** |  |
| **Country:** |  |
| **Insurance Type:** |  |
| **Insurance ID #:** |  |
| **Group #:** |  |
| **Insurance Phone # (Provider Services or Behavioral Health):** |  |
| **Parent/Guardian Name:** |  |
| **Home Phone:** |  |
| **Cell Phone:** |  |
| **E-mail:** |  |
| **Primary Diagnosis:** |  |
| **Secondary Diagnosis:** |  |
| **Subscriber Name:** |  |
| **Subscriber DOB:** |  |
| **Employer:** |  |
| **State Insurance is issued:** |  |
|  |  |
| **Secondary Insurance (if applicable):**  **Subscriber Name:**  **Subscriber DOB:**  **Insurance and Group # :** |  |

**Insurance Intake Form**

|  |  |
| --- | --- |
| **Availability for services:** |  |
| **Current School Attending:** |  |
| **Current School Hours:** |  |
| **Monday:** |  |
|  |  |
| **Tuesday:** |  |
|  |  |
| **Wednesday:** |  |
|  |  |
| **Thursday:** |  |
|  |  |
| **Friday:** |  |
|  |  |
| **Saturday:** |  |
|  |  |
| **How many hours are desired per week?** |  |
| **Other additional information:** |  |

\*\*\*Please include a copy of the back and front of both primary and secondary insurance cards\*\*\*