NETWORKS inc.

TELEPHONE INTAKE / REGISTRATION

Date:_____

Client/Patient Name: _____ D.O.B. _____

Gender: ____ Age: _____ SSN: _____ Referral Source: _____

Current Address: _____ Email: _____ Msg?

_____ Home Phone _____ ☐

Billing Address: _____ Cell Phone _____ ☐

_____ Work Phone _____ ☐

Place of Employment: _____

If Student, Name of School: _____

Parent/Guardian: _____ Legal Guardian? Yes☐ No☐

Address: _____ Phone:_____

Emergency Contact/Relationship: _____ Phone:_____

Type of Therapy requested: ☐Individual ☐Couple ☐Family ☐Group ☐Medication ☐Evaluation

Time/day preferred: _____

Current Medications:_____

Prescriber: _____ Phone _____

Primary Care Provider: _____ Phone _____

Primary Insurance: _____ Phone _____

ID/Certificate # _____ Group # _____

Policy Holder Name (if different): _____ DOB _____

Relationship to Client/Patient: _____ Remind to bring card:☐

Place of Employment: _____ Copay $ _____ Coinsurance $ _____

Secondary Insurance: _____ Phone _____

ID/Certificate # _____ Group # _____

Policy Holder Name (if different): _____ DOB _____

Relationship to Client/Patient: _____ Remind to bring card:☐

Place of Employment: _____ Copay $ _____ Coinsurance $ _____

☐ Scheduled:
Clinician:
Dx Code:
First DOS:

☐ Not Scheduled:
Reason:

TELEPHONE INTAKE / REGISTRATION

Reason(s) for seeking therapy at this time: