ADULT PATIENT INTAKE FORM

PATIENT INFORMATION
Full Name (First, MI, Last):_________________________________ Sex: Male___ Female___
Address:____ Birthdate:______________
City:________________________ State:______ Zip:_________ Soc. Sec.#_____-___-____
Home Phone: ______________ Cell:_______________ Work:_____________
Email:________________________________

RESPONSIBLE PARTY (If Minor) OR EMERGENCY CONTACT
Full Name:______________________________ Home Phone:___________________
Address:___________________________________ Cell or Work Phone:_________________
City: ________________________ State:_______ Zip:________
Relationship to Patient:______________________
How did you find Rising Phoenix Counseling Services, PLLC? (Phonebook, Website, Friend/Family, Referred, Other)
If referred, by whom?___________________________
GENERAL INSURANCE INFORMATION
Marital Status: ____________ Employment Status: ____________

INSURANCE COMPANY INFORMATION – POLICY HOLDER
First Name:_______________ MI:_____ Last Name:_________________________________
Address:_____________________________________ Home Phone:_____________________
City:_________________ State:_____ Zip:_______ Work/Cell Phone:__________________
Birthdate:________________ SS#:_____-____-______ Sex: Male____ Female____
What is your relationship to the policy holder? Spouse____ Child_____ Self_____ Other_____

IF APPLICABLE TO YOU:
Employers Name:__________________ Is this your employer's health plan? Yes____ No____
Is your signature on file?_________ Will this be covered by an EAP program? Yes____ No____
EAP contact name:_____________. What is your EAP Authorization Number?______________
If there is another Health Benefit Plan, please complete another intake form and write "Secondary Insurer" on the top of the form.

AUTHORIZATION SIGNATURES (insured's or other authorized persons)
I authorize the release of any medical or other information necessary to process this claim. I also request payment of I authorize payment of medical benefits to the
government benefits either to myself or to the party below. undersigned physician or supplier for services.

Signed:____________________ Date:________ Signed:_________________ Date:______