

CHILD Intake Form

Name of Child:			<u>Primary Insurance Company Name</u>		<u>Secondary Insurance Company Name</u>	
Child Date of Birth:		Age:	Gender: M F		Address/PO Box	
Who Referred you?			City, State, Zip		City, State, Zip	
Child's Home Address:			Insurance Phone		Insurance Phone	
City, State, Zip:						
Responsible Party Bringing Child			Name of Insured (primary)		Name of Insured (secondary)	
Your Name: _____			Your Relation to Insured Person		Your Relation to Insured Person	
Your Employer: _____			Self ____		Self ____	
Your E-Mail: _____			Spouse ____		Spouse ____	
May we email you ? Yes <input type="checkbox"/> No <input type="checkbox"/>			Partner ____		Partner ____	
Home Phone: _____			Child ____		Child ____	
May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/>			ID# of Insured		ID# of Insured	
Work Phone: _____			Group # :		Group # :	
May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/>			Group Name		Group Name	
Cell Phone: _____			Date of Birth of Insured		Date of Birth of Insured	
May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/>			Address of Insured (If Different from child's)		Address of Insured (If Different from child's)	
Name of Others in Home			Street Address		Street Address	
Birth Date			City, State, Zip		City, State, Zip	
Relation			Home Phone		Home Phone	
			Work Phone		Work Phone	
			Cell Phone		Cell Phone	
			Name(s) of People who have Legal Custody			Phone Number(s)

- I authorize the release of any health information necessary to process insurance claims for services provided by Dr Conner. This release of information expires December 31, 2010.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Conner. I request payment of government benefits either to myself or to the party who accepts assignment.
- I understand that I am fully responsible for all professional fees not covered by this assignment.
- I understand that payment in full is due at the time of service unless prohibited by Dr Conner's contract with my insurer.

Signature: _____ **Date:** _____