TELEPHONE INTAKE

Date: _______________

Referral Source/Agency: ____

Patient Name: ______________________________ DOB: ____________________

□Single □FT Employment □FT Student
□Married □PT Employment □PT Student
□Separated □Not Working
□Divorced
□Widowed
□Other:

PARENTS (IF CHILD):

☐ Married ☐Separated ☐Divorced ☐Joint Legal Custody ☐Sole Legal Custody

[If joint custody, consent from both parents is required prior to the initial appointment. Consent may be verbal.]

Address: ______________________________ City ______________ State _____ Zip ________

Phone (H) ____________________ Message ok? Phone (C) ________________ Message ok?
Phone (Other)__________________ Message ok?
Email _______________________@_____________________
Parent or Guardian Names: ____
Do both parents (or legal guardians) reside at the above address? If not, please indicate additional address:

____

PRESENTING PROBLEM:

____

INSURANCE: ______________________________ MH/SA Phone: ______________________________

ID/Group #: ______________________________ Mbr/Cust Svc Phone: __________________________
Policy Holder: ______________________________ Policy Holder Employer: _______________________
Policy Holder SSN: ___________________________ Policy Holder DOB: __________________________

□Mornings □Afternoons □Evenings

SPECIAL CIRCUMSTANCES:

Therapist Assigned: ______________________________ Psychiatry Needed? YES/NO
First Appointment Offered: ______________________________ Accepted? □YES □NO
Second Appointment Offered: ______________________________ Accepted? □YES □NO

INTAKE NOTES:

□Routine □Urgent □Emergency

BENEFIT VERIFICATION

Spoke to/Date: ____
Policy Effective Date ______________ Co-Pay? ______________ Visits/Year ______________
Deductible? ______________ Deductible met? ______________
Flex Benefit ______________ SMI Benefit? ______________
(Convert Inpatient to Outpatient)? *(If yes, Visits/Year)*