Confidential Client Intake Form CMS 1500-02/12

Last Name (2)_____ First Name_____ MI____

Address (5) _____

City _____State _____Zip _____

Phone _____ Birthday (3)___/___/___ Circle: M F

Referred By (17) _____ Phone_____

17a Referring Providers NPI number (if needed)_____

Emergency Contact Name _____Phone Number _____

Condition Related to (10) a. Employment (Y) (N) b. Auto Accident (Y) (N) c. Other accident (Y) (N)

Insured's I.D. (if different from client) # (1a) _____

Insured's Name (4) Last _____ First _____ M.I. ____

Address (7) _____

City _____State _____Zip _____

Insured's Policy/Group Number (11) _____Insured's D.O.B. (a) _____/_____/_____

Other claim ID (b) _____

Insurance Plan Name or Program Name(c) _____

Is there another health benefit plan? (d) Y ___ N ___ (If yes, fill out below)

Other insured's name (9) Last _____ First _____ MI ___

Other Insured's policy or group # (a) _____ D.O.B. (b) ___/___/____ Sex: M ___ F __

Employer's Name (c) _____Insurance Plan Name (d) _____

Release (12) : Authorized signature: I authorize the release of any medical or other information necessary to the medical treatment of my condition and to process this claim. I also request payment of medical benefits either to myself or to this medical provider.

Signature_____Date _____

Physician Diagnosis(21)_____ ICD 9 _____