Candace Young, PhD - Adult Intake Form

NAME

WHO REFERRED YOU TO ME?

DATE OF BIRTH
AGE

SEX M ☐ F ☐
MARITAL STATUS

SOCIAL SECURITY #

HOME ADDRESS
CITY, STATE, ZIP CODE
E-MAIL ADDRESS
YOUR EMPLOYER
YOUR OCCUPATION

YOUR HOME PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐
YOUR WORK PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐
YOUR CELL PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐

RESPONSIBLE PARTY
RELATIONSHIP TO PATIENT
ADDRESS IF DIFFERENT
SOCIAL SECURITY #
HOME PHONE IF DIFFERENT
WORK PHONE
EMPLOYED BY

SPOUSE ☐ PARTNER ☐
NAME

DOB
SOCIAL SECURITY #

SPOUSE'S EMPLOYER

OTHERS LIVING IN YOUR HOME NAME BIRTHDATE RELATIONSHIP TO YOU

EMERGENCY CONTACT NAME PHONE RELATIONSHIP TO YOU

PRIMARY INSURANCE

INSURANCE CO NAME
STREET ADDRESS/PO BOX
CITY, STATE, ZIP CODE
INSURANCE CO PHONE

NAME OF POLICY HOLDER
ID# OF POLICY HOLDER
GROUP #
GROUP NAME
DATE OF BIRTH OF POLICY HOLDER

RELATIONSHIP
TO POLICY HOLDER
SELF ___
SPOUSE ___
PARTNER___
CHILD ___

ADDRESS AND PHONE OF POLICY HOLDER (IF DIFFERENT)
STREET ADDRESS
CITY, STATE, ZIP CODE
HOME PHONE
WORK PHONE
CELL PHONE

SECONDARY INSURANCE

INSURANCE CO NAME
STREET ADDRESS/PO BOX
CITY, STATE, ZIP CODE
INSURANCE CO PHONE

NAME OF POLICY HOLDER
ID# OF POLICY HOLDER
GROUP #
GROUP NAME
DATE OF BIRTH OF POLICY HOLDER

RELATIONSHIP
TO POLICY HOLDER
SELF ___
SPOUSE ___
PARTNER___
CHILD ___

ADDRESS AND PHONE OF POLICY HOLDER (IF DIFFERENT)
STREET ADDRESS
CITY, STATE, ZIP CODE
HOME PHONE
WORK PHONE
CELL PHONE

FOR OFFICE USE ONLY DX USUAL PROC CODE USUAL POS USUAL FEE

- I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided by Dr Young. This release of information expires December 31, 2015.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Young. 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 Young's contract with my insurer.

Signature **Date**