# NEW CLIENT INTAKE FORM

Today's Date________________________________

**Legal Name**: ______________________________ Preferred Name: ______________________

**Date of Birth**: ______________________________ Age: ______________________

**Street Address**: ______________________________ **City, State, Zip**: ______________________

Home phone: ______________________________ **Cell phone**:______________________

**Gender as Specified on Insurance**: ☐ Male ☐ Female **Identify as**: ☐ Male ☐ Female

**INSURANCE INFORMATION** (items in **BOLD** are required)

**Insurance Company**:______________________________ Phone: ______________________

Insurance Company Address: ______________________ City, State, Zip:______________________

**Insurance Identification Number**: ______________________ **Group Number**: ______________________

**Secondary insurance**: ______________________________ Phone: ______________________

Secondary Company Address: ______________________ City, State, Zip:______________________

**Secondary Identification Number**: ______________________ **Group Number**: ______________________

**PATIENT OR AUTHORIZED PERSON'S SIGNATURE**

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

____________________________________________________

Signature Date

---

**FOR PROVIDER USE ONLY:** ICD10 DIAGNOSIS:______________________