

# Mary Andrus, ATR, LCPC



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## Intake/Insurance Information

Please print clearly.

Insured's ID Number		Date of initial visit	Insured's Policy Group or FECA Number		
Insured's Name (Last, First, Middle Initial)				Telephone (Include Area Code) ( )- -	
Insured's Date of Birth (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Insurance Plan Name		Is there another health benefit plan? <input type="checkbox"/> Y <input type="checkbox"/> N	
Insured's Address (No., Street)		City	State	Zip Code	
Patient's Name (Last, First, Middle Initial)	<input type="checkbox"/> Check here if same as insured	Patient's Telephone (Include Area Code) ( )- -			
Emergency contact (Last, First)		Relationship	Phone (Include Area Code)		
Patient's Address (No., Street)		City	State	Zip Code	
Patient's Date of Birth (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Patient relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Email	
Patient status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part Time Student		Primary Care Physician (PCP) Name			
PCP Address	City	State	Zip	PCP Phone (Include Area Code) ( )- -	
Reason seeking care at this time:					