PATIENT INTAKE FORM PROVIDER: TAX ID#____________________________
NPI#_________________________________

DATE:____________ PATIENT NAME:_________________________________ MALE__ FEMALE__ AGE_____

DATE OF BIRTH:_______________ MARRIED__ SINGLE__ STUDENT__ SS#______________________________

HOME ADDRESS:__________________________________CITY:___________________ GA ZIP;______________

HOME PHONE:__________________WORK:________________________CELL:_____________________________

OTHER PHONE:_________________________EMERGENCY CONTACT:___________________________________

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OFFICE STAFF ONLY
INSURANCE CO: BC AETNA CIGNA HUMANA UBH PHCS VALUE OPTIONS MEDICARE MEDICAID
MEDICARE CMO:_________________ AMERIGROUP WELLCARE MAGELLAN CENPATICO TRICARE SOUTH
OTHER:____________________________

ADDRESS FOR CLAIMS:PO BOX____PAYER ID#_________________

PROVIDERS CALL:_______________________________MENTAL HEALTH CALL:__________________________

SPOKE TO:____________________DATE:__________________TIME:____________________INTERNET______

INSURED NAME: SELF ________________________________ DOB:______ SS#__________________________

INS ID #:______________________________GROUP:________________________EMPLOYER:_________________

EFFECTIVE DATE:_______________ VISITS/UNLIMITED:_______ COPAY:_________ CO-INS:____% INS:___%

DEDUCTIBLE:____YES ____NO AMOUNT MET:________ AUTHORIZATION ____YES ____NO

AUTHORIZATION#:_______________________________ AX DATES:___________________________________

PROVIDER IN NETWORK?:_________ PCP REFERRAL REQ?:____________ PREEXISTING?:_____________

SECONDARY INSURANCE?:_______________ WITH:____

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FOR EAP ONLY

INSURANCE COMPANY:______________________________ PHONE:_______________________________

AUTHORIZATION #:_________________________________ # OF VISITS:____________________

AX DATES:____________________________ MAIL CLAIMS TO:____

Cpt code:_________________ Diagnosis Code:__________ _____________ ____________ _______________

ONLY FILL IN THE YELLOW SPACES AND FAX TO 770-557-0715 OR EMAIL TO : JILL@POMBLLC.COM