

Insurance Intake Form

Patient Name: _____ **Date of Birth:** _____

Gender: M F **Address:** _____

City, State, Zip: _____

Home Phone: _____ **Alternate Phone:** _____

Marital Status: Single Married Other: _____

Work Status: Employed Full-Time Student Part-Time Student Retired

Insurance Company: _____

Relationship to Subscriber: Self Spouse Child Other

(If different from above)

Subscriber's Name: _____ **DOB:** _____

Subscriber's Address: _____

City, State, Zip: _____ **Phone:** _____

Subscriber's ID # (please include prefix if applicable) : _____

Group#: _____

Employer's Name: _____ **Plan Name:** _____

Do you have another Health Benefit Plan? Yes No

If yes, please provide information on the back.

Is your condition related to:

Employment: Yes No

Auto Accident: Yes No

Other Accident: Yes No

If you were referred by a healthcare provider, please give the referring provider's name, clinic name, and phone number: _____

I understand, as the patient and/or above mentioned responsibility party, that I am fully responsible for payment of all charges incurred.

I authorize my insurance benefits to be paid directly to Christine Bowen, N.D. for services rendered. I understand I am financially responsible for any deductibles, non-covered services or non-authorized services. I authorize Christine Bowen, N.D to release any information requested by my insurance company with regards to payment of benefits.

Signature: _____ **Date:** _____

Christine Bowen, N.D
18404 102nd Avenue NE Ste. B Bothell, WA 98011
Phone: (425) 485-7441 Fax: (425) 424 -2384
info@bothellnaturalhealth.com

Additional Insurance Information

Insurance Company: _____

Relationship to Subscriber: Self Spouse Child Other

Subscriber's Name: _____ **DOB:** _____

Subscriber's Address: _____

City, State, Zip: _____ **Phone:** _____

Subscriber's ID #: _____ **Group#:** _____

Employer's Name: _____ **Plan Name:** _____

For Office Use Only

Claim Filed? Yes No Claim# _____

Pre-Authorization Obtained? Yes No

PCP referral required? Yes No

If Yes, PCP Name: _____

Phone Number: _____

PCP referral in chart? Yes No

Deductible Amount _____ Calendar Year _____

Met? Yes No Dollar/Visit Limit? _____

Copay? Yes No Amount Used _____

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