

## Insurance Intake Form

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Gender**    Male             Female

**Address** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Patient Status:**

Single                      Married                      Other \_\_\_\_\_

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

Retired                      Other \_\_\_\_\_

**Relationship to Insured Member:** (circle one)    Self    Spouse    Child    Other

**Subscriber's Name** \_\_\_\_\_ **Subscriber's DOB** \_\_\_\_\_

**Patient ID Number** \_\_\_\_\_

**Insured's Address** (if different from above) \_\_\_\_\_

**Policy Group or FECA Number** \_\_\_\_\_

**Employer's Name or School Name** \_\_\_\_\_

**Insurance Plan Name or Program Name** \_\_\_\_\_

**Referring Doctor** \_\_\_\_\_

**Do you have another Health Benefit Plan?**             YES             NO

If yes, please provide information on 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: \_\_\_\_\_

I understand, as the patient and/or above mentioned responsible 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** \_\_\_\_\_

**Additional Insurance Information:**

Relationship to Insured Member: (circle one)    Self    Spouse    Child    Other

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's ID Number \_\_\_\_\_

Insured's Address (if different from above) \_\_\_\_\_

Policy Group or FECA Number \_\_\_\_\_

Employer's Name or School Name \_\_\_\_\_

Insurance Plan Name or Program Name \_\_\_\_\_

**For Office Use Only**

Diagnoses: \_\_\_\_\_

Claim Filed     YES     NO    Claim # \_\_\_\_\_

Pre-Authorization Obtained?     YES     NO

PCP referral required?     YES     NO

If Yes, PCP Name: \_\_\_\_\_ PCP Phone Number \_\_\_\_\_

PCP referral in chart?     YES     NO

Deductible Amount \_\_\_\_\_ Met this year?     YES     NO

Copayment \_\_\_\_\_ Dollar Limit \_\_\_\_\_

Annual Visit Limit \_\_\_\_\_ Amount \$ Used \_\_\_\_\_

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