

## Intake Form

This information is needed for submitting claims and/or auditing purposes. Please fill in all areas.  
"Patient" refers to person seeking services. "Member" refers to the person who carries the insurance policy.

Patient Name \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

If minor, responsible party \_\_\_\_\_  
NAME RELATIONSHIP to PATIENT

Address \_\_\_\_\_  
STREET City State Zip Code

PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
(List all, and circle the preferred phone number)

Patient's Employer \_\_\_\_\_ Member's Employer \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_

Member ID # \_\_\_\_\_ Member's Date of Birth \_\_\_\_\_

Patient ID # \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

Refer to your insurance card for the following phone numbers:

Member Services \_\_\_\_\_  
Behavioral/Mental Health \_\_\_\_\_  
Provider Hotline \_\_\_\_\_

Gender \_\_\_\_\_ Religious Preference \_\_\_\_\_

Marital Status     Single     Married     Widowed     Separated     Divorced

Today's Date \_\_\_\_\_ Date of first scheduled appointment \_\_\_\_\_

Whom can we thank for your referral to North Shore Wellness Services?

PERSONAL REFERENCE \_\_\_\_\_  
INTERNET SEARCH \_\_\_\_\_  
INSURANCE REFERRAL \_\_\_\_\_

Name, Phone, & Relationship of a close relative/friend to alert in case of emergency:

\_\_\_\_\_

My Therapist is \_\_\_\_\_

**Session Fees & Copays:** Due at the beginning of each appointment. Payment can be made by cash, check, or credit card. Pay the therapist directly. Ask your therapist if your check should be made out to your therapist or to North Shore Wellness Services, Ltd.