Kids First Therapy

Patient Intake Form

General Information

Patient Name: (First) (M.I.) (Last)			Date: Sex: ☐ M ☐ F
Address:			DOB:
City:	State:	Zip:	County:
Name of Mother:			DOB:
Name of Father:			DOB:
Name of Guardian (if different):			DOB:
Phone: (home) (work) (cell) Appt. Reminders call/email email address: best # to leave reminder:			

Insurance Information

Name of Insured: (First) (M.I.) (Last)			DOB: Sex: ☐ M ☐ F
Address (if different):			City: State: Zip:
Employer's Name:			
Employer's Address:			
Primary Insurance:			Policy/Group #
Secondary Insurance:			Policy/Group #

Physician Information

Primary Care Physician:		Phone:
Specialists Physician Name	Specialty	Phone Number