|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **For Office Use Only** |  | | Identified Patient: |  | | CPT Intake: |  | | Billing Setup: |  | | AA Provider: |  | | |  |  | | --- | --- | | ICD10: |  | | Intake Date: |  | | Patient Gender: |  | |
| |  | | --- | | Name of Patient: | | Date of Birth: |  |  |  | | --- | --- | | Parent Names (if patient is a minor): |  | | Address: |  | | Referral Source: |  |  |  | | --- | | Home Phone: | | Work Phone(s): | | Cell Phone(s): |   Email(s): | |
| Internist/Pediatrician’s Name and Phone #: | |
| Presenting Problem(s) or Goals: | |

**Payment Information**

Credit Card #: (Visa/MC only)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_