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| **For Office Use Only** |  |
| Identified Patient: |  |
| CPT Intake: |  |
| Billing Setup: |  |
| AA Provider: |  |

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| --- | --- |
| ICD10: |  |
| Intake Date: |  |
| Patient Gender: |  |

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| Name of Patient: |
| Date of Birth: |

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| --- | --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_