

New Patient Intake



Date: _____

Name: _____ DOB: _____ Phone: _____
Last First M

Address: _____ Email: _____

Primary Insurance

Carrier: _____ ID#: _____ Group#: _____

Policy Holder: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance

Carrier: _____ ID#: _____ Group#: _____

Policy Holder: _____ DOB: _____ Relationship to Patient: _____

Guarantor (If different than the policy holder): _____ DOB: _____

Relationship to patient: _____

Signature: _____

Date: _____

Therapist: Aki Hughes-Polk, MA, LPCC, CPRP

Date of first appointment: _____

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