1400 112th Avenue SE, Suite 100, Bellevue, WA 98004
Phone: 425.202.5093

PATIENT INTAKE FORM
Date ____________________

Patient Information

Legal Name _____________________________
Preferred Name___________________________
Social Security Number ___________________
Date of Birth ________________________ Gender________ Age ____________
Street Address ____
City _________________________ State ______ Zip_____________
Preferred Phone Number_____________________________
Preferred Email Address ____

Insurance Information
Information on Primary Insurance Company
Insurance Company ____
Policy Holder's Name _____________________________Social Security Number_____________
Policy Holder's Address ____
Policy Holder's Date of Birth ____________ Insurance ID _____________________________
Policy Holder's Employer ____
Relationship of Patient to Policy Holder ____
Address of Insurance Company ____
Phone Number of Insurance Company ____
We do not bill secondary insurance but will be happy to provide you with necessary information so that you can complete your billing to them.
Email Address where statements and notifications should be sent
____
Physical Address where statements and notifications should be sent
____
____

Please explain why you are seeking professional help at this time:

____

____

Please explain any recent event/s that may contribute to present symptoms.

____

____

Would you like us to remind you of scheduled appointments? ____________
Would you like your reminder to be sent as email or text? Please provide the appropriate email or SMS. __________________________________

Signature ____

Reminder e-mails and texts are a courtesy. At times, we may be unable to provide this service. Remember that you are ultimately responsible for your scheduled appointments.