

CONCORDIA OUTPATIENT THERAPY INITIAL INTAKE FORM



Date of Intake: _____ A.L. Resident: YES NO

PATIENT INFORMATION

Last Name	First	MI	Date of Birth	Age	Social Security Number	Sex
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Address	City	State	Zip Code	Home Phone
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Have you ever received therapy services in the past? If YES, where? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Emergency Contact Person	Contact Phone Number
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Referring Physician	PCP/Family Doctor
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Employer Name	Address	Phone Number
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PRIMARY INSURANCE

Insurance Company Name	Group Number	Policy Number
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Insured's Name	Social Security Number	Date of Birth
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Insured's Employer	Address
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Type of Plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> WORK COMP <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER	CoPay <input type="checkbox"/> YES <input type="checkbox"/> NO	CoPay Amount	Does outpatient PT/OT/St need referral/Auth. <input type="checkbox"/> YES <input type="checkbox"/> NO
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SECONDARY INSURANCE

Insurance Company Name	Group Number	Policy Number
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Insured's Name	Social Security Number	Date of Birth
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Insured's Employer	Address
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Type of Plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> OTHER	CoPay <input type="checkbox"/> YES <input type="checkbox"/> NO	CoPay Amount	Does outpatient PT/OT/St need referral/Auth. <input type="checkbox"/> YES <input type="checkbox"/> NO
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