

NEW PATIENT INTAKE FORM

Which Dr. do you request to see in consultation: (please circle one)

Dr. Mitchell A. Blass, Dr. Margaret Williamson
Or First available

GAID Approval: _____

Patient Name: _____ Sex: M/F

Home Phone: _____ Cell Phone: _____

SS Number: _____ - _____ - _____ Date of Birth: _____

Referred By: MD _____ Primary Care Physician: _____

Self referred Name: _____

Internet Phone: _____

Reason for Appointment: _____

Duration of symptoms: _____

Additional Patient Information: _____

INSURANCE

Primary Insurance: _____ Phone Number: _____

Plan Id Number: _____ Group Number: _____

Insured's Name: _____ Insured's SS#: _____ - _____ - _____

Insured's D.O.B. _____ Relationship to patient _____

This plan is: In Network Out of Network Commercial/Indemnity

Insurance Effective Date: _____ Deductible Amount: \$ _____

Has the deductible been met this year? Yes No

If no, amount remaining: \$ _____

Out of pocket: \$ _____ Co-pay for office visits: \$ _____

Pre-Existing conditions? _____

Send Claims to: _____

Approved Laboratory: _____

Additional Information: _____

Spoke with: _____

Phone: _____ Verification Date: _____

GAID EMPLOYEE INITIALS: _____