This form may be downloaded and filled out for your convenience. Click here to upload once complete.

PHOENIX PREFERRED CARE CLIENT INTAKE FORM

REFERRAL DATE: _____ PERSON COMPLETING REFERRAL: _____

Demographic Information

NAME: first_____middle_____last_____

DOB: _____ AGE: _____ SEX: _____ RELIGION PREFERENCE: _____

SOCIAL SECURITY #_____

LEGAL ADDRESS: _____

_____

TELEPHONE #: _____ CELL #: _____

EMERGENCY CONTACT NAME: _____ TELEPHONE #: _____

Medical Coverage

INSURANCE/MCO PROVIDER: _____

INSURANCE MEMBER #: _____ GROUP #: _____

MEDICAID ID #: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____ DOB: _____ GENDER: ____

ADDRESS: _____

SECONDARY HEALTH BENEFIT PLAN PROVIDER: _____

INSURED MEMBER #: _____ GROUP #: _____

GUARDIAN (if applicable): _____ RELATIONSHIP:_____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

REASON FOR REFERRAL/PRESENTING PROBLEM: _____

_____

REFERRAL SOURCE: _____

ADDRESS: _____

PERSON PROVIDING INTAKE INFORMATION: _____

THERAPIST ASSIGNED: _____ DATE OF APPOINTMENT: _____ TIME: _____