

CHILD INTAKE FORM

NAME		DATE OF BIRTH	MALE/FEMALE	SOCIAL SECURITY NUMBER
HOME PHONE		HOME ADDRESS		
WHO REFERRED YOU TO ME?				
+-----+				
RESPONSIBLE PARTY #1		RELATIONSHIP TO PATIENT		
EMPLOYED BY		DOB	SSN	
WORK ADDRESS		WORK PHONE	POSITION	
+-----+				
RESPONSIBLE PARTY #2		RELATIONSHIP TO PATIENT		
EMPLOYED BY		DOB	SSN	
WORK ADDRESS		WORK PHONE	POSITION	
+-----+				
PRIMARY INSURANCE COMPANY		ADDRESS	PHONE	
INSURED'S NAME		DOB	SSN	
ID#	GROUP#	RELATIONSHIP TO PATIENT		
ADDRESS OF INSURED (IF DIFFERENT)				
+-----+				
SECONDARY INSURANCE COMPANY		ADDRESS	PHONE	
INSURED'S NAME		DOB	SSN	
ID#	GROUP#	RELATIONSHIP TO PATIENT		
ADDRESS OF INSURED (IF DIFFERENT)				

- I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided by Dr. Lennert.
- This release of information expires on _____.
- I authorize my insurance company to make payment of medical benefits directly to Dr. Lennert.
- I understand that I am fully responsible for all professional fees not covered by insurance.
- I understand that payment in full is due at the time of service unless prohibited by Dr. Lennert's contract with my insurer.
- I understand that Dr. Lennert submits insurance claims electronically through Office Ally.

Signature of responsible party

Date