poss · abilities
children's therapy group

Today's Date:______________

INSURANCE INTAKE FORM

Patient's Name : First_________________MI.______Last_____________________________

Street Address: ____

City/State/Zip ____

Date of Birth: _________________________________Gender_________________________

Name of Insured: ____

Relationship to patient:____

Insured's Date of Birth:____

Telephone Home: ____

Telephone Cell: ____

Email: ____

Insured's SS # ____

Street Address: ____

City/State/Zip ____

Spouse (if applicable) ____

Spouse's Cell ____

Spouse's Email ____

Spouse's Employer____

Insurance Carrier: ____

Insurance I.D. ____

Group Name: ____

Group Number: ____

Employer: ____

Person Responsible for Billing ____

(Please provide contact information if different than above).

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Please attach scanned copy of insurance I.D. card