

DR. JOHN K. RUSSELL & ASSOCIATES

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Client Intake Form

<i>Today's Date</i>	<i>E-mail</i>				
<i>Client(s) Name</i>					
<i>Insured's Name</i>	<i>Relationship to Client</i>				
<i>Address</i>					
<i>City</i>	<i>Zip</i>				
<i>Home Phone</i>	<i>Cell Phone</i>	<i>Work Phone</i>			
<i>Marital Status</i>	<input type="checkbox"/> <i>Single</i>	<input type="checkbox"/> <i>Married</i>	<input type="checkbox"/> <i>Divorced</i>	<input type="checkbox"/> <i>Separated</i>	<input type="checkbox"/> <i>Widowed</i>
<i>Insured's SSN</i>	<i>Driver License #</i>				
<i>Insured's Date of Birth</i>	<i>Age</i>	<i>Sex</i>			
<i>Client SSN</i>					
<i>Client Date of Birth</i>	<i>Age</i>	<i>Sex</i>			
<i>Insured's Employer</i>	<i>Position</i>				
<i>Employer Address</i>					
<i>Employer Phone Number</i>					
<i>Insurance Company</i>					
<i>Patient ID #:</i>					
<i>Phone Number</i>					
<i>Group Number</i>	<i>Policy Number</i>				
<i>Prior Authorization #</i>					
<i>Family Physician</i>	<i>City</i>				
<i>Physician's Phone Number</i>					
<i>Who referred you here?</i>					
<i>Have you had prior treatment or consultation for this condition?</i>					
<i>With whom?</i>	<i>For how long?</i>				
<i>Briefly describe your reason for coming in today.</i>					
<i>Describe any medical conditions for which you are currently receiving treatment and medications you are taking.</i>					
<i>Other comments.</i>					