

Pitts & Associates  
601 Beacon Parkway West, Suite 201  
Birmingham, AL 35209  
**Adult Intake Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #1: \_\_\_\_\_ (text appt reminders) Phone #2: \_\_\_\_\_

Employed By: \_\_\_\_\_

Email Address: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employed By: \_\_\_\_\_

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PRIMARY \_\_\_\_\_

Policy Number \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Birth date of Subscriber: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

SECONDARY \_\_\_\_\_

Policy Number \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Birth date of Subscriber: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

I understand that, as a courtesy to me, Pitts & Associates files my insurance. I understand that Pitts & Associates is NOT responsible for keeping up with my insurance company's deductible, co-pays and/or the number of visits authorized by my Insurance. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient or Responsible Party  
(typed name constitutes signature)