Pitts & Associates 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_____ SECONDARY_____

Policy Number_____ Policy Number _____

Subscriber's Name: _____ Subscriber's Name: _____

Birth date of Subscriber: _____ Birth date of Subscriber:_____

Relation to patient: _____ Relation to patient: _____

Employer: _____ 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)