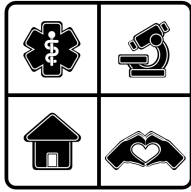


FOUR SQUARE CLINICALS
INTAKE PACKET

Patient Name: ____ Jr. / Sr. / III   Marital Status: S M D W O
(Last) (First) (MI)

Address (Mailing): ___________________________________ City: ___________ State: ______ Zip: _______

Physical Address (If Different): ____

Sex: M or F or Other. Date of Birth: ________________ Social Security #: ________________________________

Email: ____ Home Phone: _______________________

Cell Phone: _______________________ Work Phone: _____________________

Employer: _____________________________ Address: ____

City: ________________________ State: ____ Zip: __________ Occupation: __________________________

Whom may we contact in case of emergency: _____________________________

Relationship: _______________________ Phone: __________________________

Are there other members of the immediate family who have already been to this office? Y or N

If so, list their names:

____

Who may we thank for referring you?

____

INSURANCE INFORMATION

Primary Insurance

Patient's Insurance ID#: ____

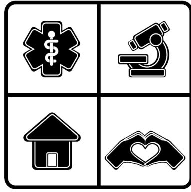
Subscriber (whose job provides plan?): ____
(Last) (First) (MI)

Subscriber's Date of Birth: ___________ Sex: M or F or Other. Subscriber's Social Security #: ________________

Insurance Company: _______________________ ID #: ____________________ Group#: _________________

Second Insurance? Y or N   Patient's Insurance ID#: ____

Subscriber: ____
(Last) (First) (MI)



FOUR SQUARE CLINICALS
INTAKE PACKET

Subscriber's Date of Birth: __________ Sex: M or F or Other. Subscriber's Social Security #: ________________

Insurance Company: ________________________ ID #: ____________________ Group #: ________________

If there is a third plan, please put information on back.

Is this related to a: Court Order or Worker's Comp?

Ultimately, who is responsible for the bill (the Guarantor)?: ____

Address: ____

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

If required, I hereby authorize payment directly to Four Square Clinicals and the provider responsible for my care. I understand that I am financially responsible to Four Square Clinicals for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third-party payor in order to obtain payment. I hereby authorize Four Square Clinicals to release any medical information required for my examination or treatment. I understand that payment is expected at rendering of services unless other arrangements have been made. I hereby also consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even if I have some type of insurance coverage, I am responsible for payment of services.

______________________________________ ______________________________

Signature of Responsible Party (relationship) Date