



PACIFIC NORTHWEST
OCCUPATIONAL THERAPY LLC

Improving your quality of life.

INITIAL INTAKE FORM

• Name of Patient: _____ DOB: _____ Age: _____

Address _____

Mailing Address (if different) _____

Ph _____ Alt Ph _____ Social Security # _____

• Email address: _____

Can we send you health related emails? YES NO

• Emergency Contact/Parent (if minor) _____ Ph _____

Do you have a DNR? YES NO

• Who Referred _____ PH: _____ Fax: _____

Reason for Referral/Diagnosis _____

Office Use Only: ICD-9 Code: _____

***If you have a prescription please bring to first appointment (if billing through insurance)**

Name of Primary Insurance to bill for services: _____

Claim/ ID #: _____ Group #: _____

Secondary Insurance (if available): _____

***Please bring insurance cards to first appointment.**

• Do you want us to verify your insurance coverage? YES NO

If yes: Phone #: _____

Name of insured (if other than client): _____ Date of Birth: _____

Social Security #: _____ Relationship to Client: _____

Office Use Only: OT covered benefit _____ # visits \$ _____ /calendar year

Prior auth required, method _____

Deductible \$ _____ Amount met \$ _____ Max out of pocket \$ _____ Copay \$ _____ /visit

Paid by insurance _____ % Paid by subscriber _____ % Other _____

Date _____ Contact _____ Ph _____

***Each insurance carrier varies in coverage, please be informed of deductibles or co-pays that may be your responsibility.**