# LPL Medical Billing Services

*The Mental Health Claims Processing Firm for "Peace of Mind"*

## *PATIENT INTAKE FORM*

*Provider:* _____

**PATIENT INFORMATION:**

Last Name: _____ First Name: _____ □ Male □ Female

Age: ____ Date of Birth: _____ Social Security Number: _____

Address: _____ Phone: (H) (W) (C) _____

_____ Email: _____

City: _____ State: _____ Zip Code: _____

**INSURANCE INFORMATION:**

*Please check one*: □ PRIMARY □ SECONDARY

Insurance Carrier: _____ Phone #: _____

Policy ID#: _____ Group #: _____

Policy Holder: _____ Relation: _____ Date of Birth: _____

*Please check one (if applicable)*: □ PRIMARY □ SECONDARY

Insurance Company: _____ Phone #: _____

Policy ID#: _____ Group #: _____

Policy Holder: _____ Relation: _____ Date of Birth: _____

**EMERGENCY CONTACT:**

Contact Person: _____ Relation: _____

Contact Number(s): (H) (W) (C) _____ (H) (W) (C) _____

***Patient Signature:*** _____ ***Date:*** _____

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