Phone Intake Form Date_____

Client First Name _____ Middle _____Last Name _____

What program are you interested in? _____

Medical Diagnosis or Reason for Therapy? _____

DOB _____ ☐ Male ☐ Female Mayo Clinic/OMC #_____

Address_____

Email: _____

Home Phone_____ Mobile Phone_____

Appointment reminder via: ☐ Text ☐ Email

Mobile Carrier: ☐Verizon ☐ATT ☐Sprint ☐Other_____

Physician Name _____ Phone: _____

Facility: ☐ Mayo ☐OMC ☐Other Clinic Name: _____

Primary Language if not English: _____

GROUP HOME CLIENTS ONLY:

House Coordinator Name _____ Phone_____

Email _____ Facility _____

PEDIATRIC CLIENTS:

Primary Contact: _____ Relationship: _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID#_____

Secondary Insurance: _____ ID#_____

Tertiary if applicable: _____ ID#_____

- Please provide a copy of Doctor's referral or order.
- Please bring insurance cards for copy
- Please provide a list of medications.
- Fax: 888-624-3107