

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