

**PATIENT INTAKE QUESTIONNAIRE**

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| **PATIENT INFORMATION** | | | | | | | | | | | | | |
| Patients Last Name: First: Middle: | | | | | | | □Mr.  □Mrs. | | | □Miss.  □Ms. | | MARITAL STATUS (CIRCLE ONE) SINGLE/ MAR / DIV / SEP / WID | |
| Social Security: | | | | | | | Birth date: | | | | | Age: | Sex:   * M □ F |
| Street address: | | | | | | City/State/Zip: | | | | | | Phone: | |
| Employer: | | | | | | Occupation: | | | | | | Employers Phone number: | |
| **EXCLUSIONS:**  □ SUICIDAL IDEATION □ METH INTOXICATION □ VIOLENT □ BORDERLINE PERSONALITY □ SCHIZOPHRENIA | | | | | | | | | | | | | |
| **REFERRAL PARTY INFORMATION** | | | | | | | | | | | | | |
| If you were referred by a physician, therapist or interventionist or other, we would appreciate you providing their contact information: | | | | | | | | | | | | | |
| Name: | | | Phone Number: | | | | | | | | I hereby authorize Kyle ER to release my medical records regarding this care to my referring party  YES  NO | | |
| **DISPOSITION** | | | | | | | | | | | | | |
| When does the referring party wish to be notified?  Where do you want the patient dispositioned to?  Additional Notes: | | | | | | | | | | | | | |
| **HEALTH INSURANCE INFORMATION** | | | | | | | | | | | | | |
| WE ACCEPT ALL COMMERCIAL INSURANCE POLICIES; HOWEVER, WE DO NOT ACCEPT MEDICARE, MEDICAID, TRICARE, VA, OR MARKETPLACE.  PLEASE PROVIDE THE FOLLOWING INFORMATION FROM YOUR HEALTH INSURANCE CARD | | | | | | | | | | | | | |
| Please indicate primary insurance |  | | | Please indicate secondary insurance | | | | |  | | | | |
| Subscribers name: | | | | Subscribers S.S #: | | | | | | | | | |
| Patient’s relationship to subscriber Self Spouse Child Other | | | | | | | | | | | | | |
| POLICY IDENTIFICATION # | | | | | GROUP IDENTIFICATION # | | | | | | | | |
| INSURANCE PROVIDER TELEPHONE #: | | | | | CUSTOMER SERVICE TELEPHONE #: | | | | | | | | |
| **EMERGENCY CONTACT**  Policy #: | | | | | | | | | | | | | |
| Name of local friend or relative: | | Relationship to the patient: | | | | | | Phone Number: | | | | | |
| The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize KYLE ER to release any information required to process my claims.    Patient/Guardian Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_    Thank you very much for the time you have taken to complete this questionnaire. We will respond to your inquiry in a timely manner and look forward to working with you!  Sincerely,  Kyle ER & Hospital | | | | | | | | | | | | | |