Rick Slinkard MFT www.sdmft.com
San Diego Marriage and Family Therapy.com
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Initial Intake Face Sheet

Today's Date: ______________________

Client Name:_____________________________________ **DOB**: _____________ Age: _________

Address:____

City:____ **State**:______________ **Zip:** __________

Home Phone:______________________________________ **Cell** (Self/Parent):_____________________

Responsible Party if Ct. is Minor:____

Employer:____ Work Phone: ________________________

If Student, Where/Grade:____________________________ E-Mail Address: _____________________

Emergency Contact: ________________________________ Phone #: _____________________________

Primary Care Provider: ____________________________ **Phone #**: _____________________________

PCP Address: ____

Current Medications: ____

Name, #, and address of Professional that referred you:____

____

Client's Insurance Company: _______________________ Card #: _____________________________

Insurance Phone #: _______________________ **Initial Copay/Extended Copay**:___________________

Subscriber: _______________________________________ **Subscriber's DOB:** ___________________

Subscriber's Relation to Patient: ____

Subscriber's Address if different than patients: ____

Insurance Group #: ________________________________ Subscriber's Employer:_______________

Authorization #: ______________________________ **# of Sessions:** _________

Effective Date: ________ **Expiration Date:**______________ **Total # Session Per Yr Benefit:**________

If there is secondary insurance, Ins. Co. Name: ____
Card Number: ____

I hereby authorize by my signature that:
1.____ **(Y/N)** Richard Slinkard MFT may contact and coordinate my treatment with my Primary Care Physician.
2.____ **(Y/N)** As insured or authorized person, I hereby assign any insurance benefits to Rick Slinkard MFT and authorize him to furnish any necessary information needed to submit and process claims to my insurance company.

Client/Legal Guardian Signature: _______________________________________ **Date:** __________