The **Learning** Fountain, Inc. 2819 Crow Canyon Rd. #205 San Ramon, CA 94583 PH: 925.264.9810 FAX: 925.263.1906

NEW PATIENT INTAKE & INSURANCE FORMS

New Patient Demographics **Today's Date: ____-____-____**

Patient's Legal Name: ____Sex: M / F
(Last) (First) (Full Middle)
How does patient wish to be addressed: __________________________________Date of Birth: ___-___-___

Address: ____
(Number) (Street) (Apt #)
City/ State/ Zip Code: ____

Are you a new patient: Yes_____ No_____ Returning Patient: Yes_____ No_____

Primary Care Provider: ______________________________ Referred By: ____________________________

Diagnosis: ____

Parent's Concerns: ____

Mother's Contact Information

Name: ____Date of Birth: _____________________

Home Phone: (____) ___________Cell Phone: (____) ____________Work Phone: (____) ____________

Address (If Different From Above): ____

Email Address: ____

Employer's Name: ___________________________________Position:____________________________

Father's Contact Information

Name: ____ Date of Birth: _____________________

Home Phone: (____) ___________Cell Phone: (____) _____________Work Phone: (____) ____________

Address (If Different From Above): ____

Email Address: ____

Employer's Name: _____________________________________Position: ___________________________

Legal Guardian's Contact Information (if different from avove)

Name: ____Date of Birth: _____________________

Home Phone: (____) ___________Cell Phone: (____) _____________Work Phone: (____) ____________

Email Address: ____

Address (If Different From Above): ____

Employer's Name: ______________________________________ Position: __________________________

Emergency Contact: __________________________________***Phone:***_____________________________

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NEW PATIENT INTAKE & INSURANCE FORMS

Section II: Subscriber Information/Primary Insurance Holder Section

Legal Name: ____
(Last) (First) (Middle)

Date of Birth: ________________________________ CADL# __________________________________

Address: ____
(Number) (Street) (City) (State) (Zip)

Home Phone #: (____) _____-______ Business Phone #: (____) _____-______Cell #: (____) ______-______

Employer's Name: ____

Occupation: ____

Section III: Insurance Coverage

Primary Insurance Company: ____

Billing Address: ____

Subscriber ID#: ____

Date Valid From: _________________To: _________________ Last 4 SSN: ______________________________

Patient's Relationship to Insured: ____

Secondary Insurance Company: ____

Billing Address: ____

Subscriber ID#: ____

Date Valid From: _________________To: _________________ Last 4 SSN: ______________________________

Patient's Relationship to Insured: ____