Craig H. Robinson, Ph.D., Inc.

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Intake Form

Name: _____

Address: _____

Phone: Home: _____ Mobile: _____ Work: _____

Email: _____ Date of Birth: _____

Occupation: _____ Employer/School: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Name of Spouse/partner: _____ Date of Birth: _____

Phone: Home: _____ Mobile: _____ Work: _____

Occupation: _____ Employer/School: _____

Referred to this office by: _____

Dr. Robinson may thank the person who referred you: ◯ YES ◯ NO

Medical Insurance: _____ Policy # _____

Subscriber's Name: _____ Date of Birth: _____

Preferred payment method: ◯ MasterCard ◯ Visa ◯ Amex
◯ Cash ◯ Check ◯ Other

Please read the handout *Frequently Asked Questions and Conditions of Evaluation and Treatment*, which is yours to keep for your records.

Please check one of the items below:

☐ I have read, understand, and agree to the conditions described in *Frequently Asked Questions and Conditions of Evaluation and Treatment*. I also have been shown and offered a copy of the *Notice Form*. I authorize the release of any information requested for completion of medical claims to my insurance carrier for services rendered.

☐ Before signing, there are some issues I would first like to discuss with Dr. Robinson.

_____ _____

Signature Date

For Office Use Only

Dx: _____ Co-Pmt _____

Cov: _____ CPT: _____