

\_\_\_\_New Patient

**CNS PATIENT INTAKE FORM**

\_\_\_\_Est. Patient

*BAKER CAMPBELL COLON DERNBACH HERNANDEZ-FRAU JUSTIZ RABBANI SANTIAGO KRUEGER*

INITIALS/DATE \_\_\_\_\_ ACCT# \_\_\_\_\_ REFERRING MD \_\_\_\_\_

APPOINTMENT DATE \_\_\_\_\_ TIME \_\_\_\_\_ AM/PM \_\_\_\_\_ SEX M F

PATIENT LEGAL NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_ HOME PHONE \_\_\_\_\_ ALT # \_\_\_\_\_

SYMPTOMS \_\_\_\_\_ SYMPTOMS STARTED \_\_\_\_\_

<u>TEST</u>	<u>AREA OF BODY</u>	<u>FACILITY</u>	<u>DATE</u>	<u>PT TO BRING</u>

MEDICARE ID# \_\_\_\_\_ MEDICAID ID# \_\_\_\_\_ SELF PAY

COMMERCIAL INSURANCE \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURER'S NAME \_\_\_\_\_ POLICY # \_\_\_\_\_ REL. \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

WORK COMP/AUTO \_\_\_\_\_ CLAIM# \_\_\_\_\_ DOI \_\_\_\_\_

BILLING ADDRESS \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADJUSTER NAME \_\_\_\_\_ PHONE# \_\_\_\_\_ EXT \_\_\_\_\_

NURSE CASE MGR \_\_\_\_\_ EXT# \_\_\_\_\_ FAX # \_\_\_\_\_

**PATIENT INSURANCE BENEFITS VERIFICATION**

In-Network \_\_\_\_ Out of Network \_\_\_\_ PCP REFERRAL Y \_\_\_\_ N \_\_\_\_ EFFECTIVE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

CLAIMS ADDRESS \_\_\_\_\_ Group# \_\_\_\_\_

\_\_\_\_ Payor ID # \_\_\_\_\_

SPECIALISTS OFFICE Co -Pay \_\_\_\_\_ or Co-INSURANCE \_\_\_\_\_ % DEDUCTIBLE \_\_\_\_\_ MET Y \_\_\_\_ N \_\_\_\_

OOP \_\_\_\_\_ MET Y \_\_\_\_ N \_\_\_\_ NETWORK ACCESSED \_\_\_\_\_

PRECERT REQUIRED	Co-Pay	Co-INSUR %	PHONE
Y N DIAGNOSTIC TESTING	_____	_____	_____
Y N PAIN MANAGEMENT	_____	_____	_____
Y N IN PATIENT SURGERY	_____	_____	_____
Y N OUT PATIENT SURGERY	_____	_____	_____
Y N DME	_____	_____	_____

IF DME IS OVER \$ \_\_\_\_\_ PRECERT REQUIRED/DME LIMITS \$ \_\_\_\_\_ PER \_\_\_\_\_

PRE-EXISTING CONDITION Y \_\_\_\_ N \_\_\_\_ ENDING DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ REP NAME \_\_\_\_\_