

6005 Salem Road S.W.
Rochester, MN 55902
Telephone: (507)281-3033
Fax: (507)281-7692

INTAKE FORM-ADULT

Date: ____/____/____

Full Name: _____ Age: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ (Home) _____ (Work)

Cell Phone: _____

Do you have a Living Will? Yes No (Please circle one)

Years of Education: _____ Occupation: _____

Marital Status: (Circle) Never Married Married Divorced Widowed

Employer Name: (Name, Address, Telephone) _____

PAYMENT/INSURANCE INFORMATION: (PLEASE COMPLETE ACCURATELY)

Do you have sufficient funds to pay for these services if not fully covered by insurance? _____

Name of Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____

Policy ID Number: _____ Group Number: _____

Social Security # of Insured: _____ - _____ - _____

THE FOLLOWING INFORMATION IS FOR USE ONLY IN EMERGENCY:

Name of Spouse or Next of Kin: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Business Phone #: _____

Cell Phone #: _____

Does above know of this visit? _____

Relationship to you: _____

