BodyIntel Patient Information Sheet

Patient Information:			
Patient Name:			
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Date of Birth:	**Social Security No:**		
Employer/School:	**Occupation:**		
E-mail Address:	**How did you hear about us?**		
Physician's Name:	**Physician's Phone Number:**		
Area(s) to be treated:	**Date of Injury/Onset of Symptoms:**		
Surgery: ☐Yes ☐No Date of Surgery_____	**Other Comments:**		
Spouse, Parent/Guardian, Other:			
Name:	**Relationship to the patient:**		
Address:	**Phone Number:**		
Employer:	**Work Phone:**		
In Case of Emergency, whom shall we contact?	**( ) -**		
Insurance Information:			
Primary Ins. Company:	Phone #:		
Address:	City:	State:	Zip Code:
ID/Claim Number:	Group Number:		
Insured Name:	DOB:	Relationship to the Patient:	
Secondary Ins. Company:	Phone #:		
Address:	City:	State:	Zip Code:
ID/Claim Number:	Group Number:		
Insured Name:	DOB:	Relationship to the Patient:	

For Office Use Only:					
Date Verified:	Effective Date:		Insurance Rep Name:		
In-Network % Covered:			Out of Network % Covered:		
In-Network Deductible:			Out of Network Deductible:		
Amount Met:			Amount Met:		
Co-Pay:	Visits:	Auth$:	Co-Pay:	Visits:	Auth$:
Auth# (Pre-cert#):			Auth# (Pre-cert#):		
Auth to:	Auth From:		Auth to:	Auth From:	
Comments: Family/Deductible/Met?					
BodyIntel Inc. Rep:			Pt. notified of benefits: ☐Yes ☐No Date:		

The information I provided in the medical history, patient information and insurance sections are accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

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