Anderson Integrative Medicine, PLLC
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Intake Information

Date______________________

Patient Name____ Date of Birth______________
Last First Middle

Age_______ Occupation____

*If Patient is under 18: Parent/Guardian Name: ____
Last First Middle

Address ____

____

Day Phone______________________________ Evening Phone______________________

Patient Social Security #____________________________________

Health Insurance Company____________________________

Secondary Health Insurance____________________________

Primary Policy Holder____
Last First Middle

Policy Number______________________________________

Primary Policy Holder Date of Birth____________________

Emergency Contact___________________________ Relation______________________

Phone______________________________________

Are you being seen for work related complaint? _______Y ________N

If yes, Date of Injury/Accident____________

Insured Patients Please read and Sign.
I hereby assign my right and authorize and direct my insurance company, or any other liable insurance company, or any other concerned party, including but not limited to Medicare, to make payment directly to Anderson Integrative Medicine, PLLC and/or Matt Anderson, F.N.P.
This assignment and direct payment authorization shall include any payments for the doctors services rendered at Anderson Integrative Medicine, PLLC.

I understand that I am responsible for any amount billed that my insurance company does not cover.

Authorization Signature____