



Billing Intake Form

Patient First Name

Patient Last Name

Patient Date of Birth

Male

Female

Other

Referral Source

Referred To

Street Address

City, State, Zip

Home Phone

Mobile Phone

Email

Responsible Party First Name

Responsible Party Last Name

Relationship to Patient

Billing Address

City, State, Zip

Home Phone

Mobile Phone

Email

Please indicate any restrictions and/or preferences regarding phone calls, phone messages, and email:

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