

Michelle Wong LAc - (310) 806-3974

In Ntwk *Out of Ntwk*

Patient Intake

Date: _____

Patient Name: _____	D.O.B.: _____
Insurance Carrier: _____	Ins. Phone: _____
Emergency: _____	ID/Claim #: _____

Type: *Symptoms Began / Date of Accident:* _____

Patient Information Chief Complaint: _____ Male Female

Full Address _____

Phone _____ Email _____

Marital Status: *Employment Status:* *Relationship to Insured:*

Insured Information Ins. ID #: _____ Male Female

Name: _____ D.O.B.: _____

Full Address: _____

Plan Information Group: _____ Plan: _____

Calendar / Plan Year: Calendar Plan *Effective:* _____

Claims Address: _____

Sub to: _____ Payer ID: _____

Deductible IN: _____ OUT: _____

	Acupuncture	Office Visit	Physical Therapy
Covered @ IN/	% of allowed	% of allowed	% of allowed
OUT/	% of allowed	% of allowed	% of allowed
Copay/Co-Ins: IN/			
OUT/	Balance	Balance	Balance
Yearly Max / Used			
Combined with:			

Notes: _____

Ref #: _____ Carrier Rep: _____