CRESPO & ASSOCIATES, P.A.
INTAKE FORM

Date: Account# Appt. Date:

Dr. C (Hisp only) Staff Initials Appt. Time:

New Patient Information

Patients Name: First MI Last

Social Security#: DOB: Sex: M / F Spouse:

Race: ❏ White ❏ Hispanic ❏ Black ❏ Asian ❏ Other ____________ ❏ Unknown

Ethnicity: ❏ Hispanic/Latino ❏ Non Hispanic/Latino

Address: City: State: Zip:

Home Phone #: ( ) Pager/Cell Phone #: ( )

Email Address:

Employer Name: Occupation: Work Phone # ( )

Current Treating Physician: ____________________
Did you go to the E.R.? No / Yes Which one? ____________________
What tests were completed? (circle all that apply) X-rays? Ct scan? MRI? Were you admitted? Yes No

Emergency Information - Contact: ____________ Relationship to Patient:__________Phone # (_____)_________
Who may have access to your personal health information? ____________________

Insurance Information

Type of Claim: HEALTH, W/C, PIP, PPP, Cash, IME $ Date of Injury: Was it work related? Y / N

Were you the driver, passenger, pedestrian, bicyclist, motorcycle, other? ____________________
Do you own a car? Yes / No If "No", do you live with a relative who owns a car? Yes / No
Name and phone # of the relative you live with: ____________________

Primary Insurance:

Claim #: Policy #:

Claims Address: City: State: Zip:

Phone #: ( ) Fax #: ( )

Insured: Adjuster: Ext.:

Pip: % Med Pay: Y / N Deductible Amount: Met? Y/N

Secondary Insurance:

Member #: Policy / Contact / Group #:

Insured: SS #:

Deductible Amount: Met? Y / N Effective Date:

Primary Care Physician

Physician's Name: Phone #: ( )

Notes:

I hereby authorize payment directly to this office for professional services rendered and I shall be responsible for any balance left unpaid by any insurance company to the doctor. I give C & A my consent to treat me. The above information is correct and true to the best of my knowledge.

Date:______________________ **Patient/Guardian Signature:** ______________________