

Acct # _____
HCA Dr: _____

**HAUSER CLINIC AND ASSOCIATES
DATA INTAKE FORM**

In order to assist us in providing you with quality services, and to facilitate reimbursement, please fill out this form and sign where indicated.

PATIENT INFORMATION: Referred By: _____ Today's Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Birth Date: ____/____/____ Current Age: ____ SSN: ____-____-____ Sex: ____

Race: Asian African American Caucasian Hispanic Native AM Indian Other

Marital Status: Single Married Divorced Widowed E-Mail _____

Address: _____

Preferred Language: Arabic Chinese English French German Italian Japanese Korean Portuguese
Russian Spanish

Patient Street Address: _____ Apt#: _____

City: _____ State: _____ ZIP: _____

Phone: Home ____-____-____ Work ____-____-____ Cell ____-____-____

Confidential Preference (contact you by): Email Mail Main Phone Phone 2 Phone 3

Person Responsible for Payment: _____ Relationship: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ ZIP: _____

Phone: Home ____-____-____ Work ____-____-____ Cell ____-____-____

Employer (or School): _____ Occupation: _____

Address _____

Education Level: GED High School College (associate degree) Bachelor's Degree or Higher

Spouse's (or Parents') Name: _____ Spouse's: DOB ____/____/____ SSN ____-____-____

Spouse Employer: _____ Occupation: _____ City: _____ Work Phone: ____-____-____

Emergency Contact: _____ Relationship: _____ Phone: ____-____-____

Primary Care Physician: _____ Phone: ____-____-____

Pharmacy: _____ Phone ____-____-____

Are you required by a judge, the police or a probation/parole officer to have the appointment? Yes No

Is the problem related to an accident or injury? Yes No If yes, is it automobile or work related?

If yes, date of injury: _____

Is counseling related to a legal claim? Yes No

If yes, Attorney: _____ Phone ____-____-____

I consent to treatment by a provider of the Hauser Clinic and Associates, P.A. I understand that payment is to be made at the time of the session, and that I am financially responsible for all scheduled appointment unless a minimum of 24 hours notice is given. I authorize provider of care to release my treatment records, as required, to my primary care physician and to the insurance carrier(s) for the purpose of obtaining reimbursement. I authorize payment of reasonable and customary charges to the provider of services. This release will terminate one year from my last appointment unless a written notice of extension is given.

I have reviewed over Hauser Clinic and Associates, P.A. **Notice of Privacy Practices**; I consent to acknowledgement of the Practices.

Signature of Patient/Guardian: **X** _____ Date: ____/____/____

Signature of Witness: **X** _____ Date: ____/____/____