Healthcare Helper Heather, LLC

Client Intake Form

All information will be kept confidential and used solely for the purpose of providing personalized healthcare navigation support.

Client Information

- **Full Name:** _____
- **Address:** _____

  City: _____ **State:** _____ **Zip Code**: _____
- **Date of Birth (DOB):** _____ / _____ / _____
- **Phone #1:** (_____) _____ – _____
- **Phone #2:** (_____) _____ – _____
- **Email:** _____

Health Insurance Information

Primary:

- **Insurance Plan Type:** _____
- **Member ID Number:** _____
- **Name of Primary Insured:** _____

Secondary:

- **Insurance Plan Type:** _____
- **Member ID Number:** _____
- **Name of Primary Insured:** _____

Emergency Contact Information

- **Name: _____**
- **Phone Number:** (_____) _____ – _____
- **Relationship to Client: _____**

List of Client's Doctors

(Please include as much detail as possible. Attach additional pages if needed.)

Doctor Name	Specialty	Phone Number	Address

Questions, Comments, or Concerns:

(Please share anything you'd like me to know or discuss further.)

_____

_____

_____

_____

_____

Signature: _____ **Date: _____ / _____ / _____**