



**Patient Intake Form**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Sex: Male Female Marital Status: Single Married Partner Widowed

Employment Status: Employed Self-Employed Unemployed Student Retired

How did you hear about our office? \_\_\_\_\_

**Patient Employer Information**

Name: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

**Spouse Information**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Emergency Contact (Other Than Spouse)**

Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Payment/Insurance Information:**

Who is responsible for your bill? Self / Spouse / Parent / Health Insurance / Medicare / Medicaid

Personal Health Insurance Carrier: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Insurance Card ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\*\*Please note SoftWave Therapy is usually not covered by insurance\*\***

**HIPAA Privacy Practices**

I acknowledge that I have received and /or have been given the opportunity to review Triton Wellness Solutions and SoftWave Therapy Office's Notice of HIPAA Privacy Practices for protected health information.

**Consent to Bill Insurance**

I hereby grant permission to Triton Wellness Solutions & SoftWave Therapy to submit medical claims directly to my insurance company for all medical services rendered. I understand that Triton Wellness Solutions & SoftWave Therapy will adhere to all regulations and guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA) to ensure the protection and confidentiality of my personal and medical information. I understand that I am responsible for any co-pays, deductibles, or charges not covered by my insurance policy. I also understand that failure to fulfill my financial obligations may result in the discontinuation of treatment. I authorize the release of any medical information necessary to process my claim. I also authorize payment of medical benefits to Triton Wellness Solutions & SoftWave Therapy for services provided.

Please Note: This consent will remain in effect until written notice is provided to revoke this consent.

Print Patient Name : \_\_\_\_\_

Patient Signature : \_\_\_\_\_

Date: \_\_\_\_\_

**Consent to Treat a Minor**

I hereby give my consent to Triton Wellness Solutions & SoftWave Therapy and its medical staff to administer medical treatment as deemed necessary to my minor child, in the case of an illness, injury, or other health condition that requires immediate attention.

(Minor's Printed Name): \_\_\_\_\_

Guardian / Parent Signature Authorizing Care: \_\_\_\_\_