Intake Form

Patient Name*

Address* City* State* Zip Code*

Phone Number* Gender* Date of Birth*

Support Coordinator name at DDD* Support Coordinator contact information*

Parent/Guardian Name(s)*

Email of parent/guardian*

Client Doctor (Full Name)* Doctor's Fax Number*

Diagnosis*

Insured Name IF ins is other than AHCCCS or DDD

Insured Phone Number Insured Gender Insured DOB

Insured Employer Insured Employer Phone

Insurance Company Name IF other than AHCCCS or DDD

Effective Date Plan (HMO/PPO/Other)

Billing Address

Insurance Company Phone

ID # Group #

Authorized Signature