AIBH New Patient Web Request Form (Patient Complete ONLY Sections with *)

*Date of Patient Request _____ Request Retrieved by _____

*Patient Referred by _____ *Reason for Visit _____

*Clinician Patient Requested _____ Clinician Assigned by Staff _____

Clinician Accepted by Patient □ *Yes* □ *No* *Clinician's Signature* _____

*Last Name of Patient _____ *First Name of Patient _____

*Address _____

*City _____ *State _____ *Zip _____

*Home # _____ *Cell # _____ *Office #_____

*Birth Date _____ *Email Address _____

Date of Appointment _____ *Scheduled by* _____

*Primary Insurance _____ *ID # _____

*Policy Holder Birth Date _____ *Group Number _____

*Insurance Phone # _____ *Effective Date of Policy _____

*Name of Policy Holder _____ *Relationship _____

*Claim Address _____ *Ins. Payer ID _____

Copay _____ *Visits Per Year* _____ *Authorization Required* □ *Yes* □ *No*

Authorization Effective Dates _____

CPT Code/Codes _____

Number of Visits _____ *Authorization Number* _____

REFERENCE NUMBER _____ *Staff Member* _____

*Secondary Insurance _____ *ID # _____

*Policy Holder Birth Date _____ *Group Number _____

*Insurance Phone # _____ *Effective Date of Policy _____

*Name of Policy Holder _____ *Relationship _____

*Claim Address _____ *Ins. Payer ID _____

Copay _____ *Visits Per Year* _____ *Authorization Required* □ *Yes* □ *No*

Authorization Effective Dates _____

CPT Code/Codes _____

Number of Visits _____ *Authorization Number* _____