AIBH New Patient Request Form

(Patient complete ONLY Sections with *)

Patient Accepted by Clinician __ Yes ___No

*Clinician's Signature*_____

*Date of Patient Request_____ Request Received by_____

*Patient Referred by_____ *Reason for Visit_____

*Reason for Leaving Current Provider (If applicable) _____

*Clinician Patient Requested_____ Clinician Assigned by Staff_____

*Last Name of Patient_____ *First Name of Patient_____

*Address_____

*City_____ *State_____ *Zip Code_____

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

*Birth Date_____ *Gender_____*Identifies As_____

*Preferred pronouns_____ *Email Address_____

*Primary Insurance_____ *ID#_____

*Policy Holder Birth Date_____ *Group Number_____

*Name of Policy Holder_____ *Relationship_____

*Insurance Phone#_____ *Effective Date of Policy_____

*Secondary Insurance_____ *ID#_____

*Policy Holder Birth Date_____ *Group Number_____

*Name of Policy Holder_____ *Relationship_____

*Insurance Phone#_____ *Effective Date of Policy_____