



FRINGE MEDICAL BILLING LLC

10357 Lima Street
Hollywood, FL 33026
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Emmaus Family Counseling

Patient Intake Form – Provider:

Date: _____ Social Security # _____

Patient Name: _____ Insurance Company: _____

Patient Address: _____ Ins. Co. Phone#: _____

_____ Ins. Co. Address: _____

Patient Phone#: Home _____ Social Security # insured _____

Cell _____ Policy #/ ID #: _____

Work _____ Group #: _____

Patient date of birth: _____ Insured Name: _____

Gender: _____ Marital Status: _____ Insured Address: _____

Social Security#: _____ _____

Employer: _____ Insured Phone #: _____

_____ Insured DOB: _____

Appointment date: _____	DX Code: _____
Procedure Code: _____	_____
Units: _____	_____
Fee: _____	
\$ Patient paid: _____	