PINNACLE
PERFORMANCE

NEW CLIENT INTAKE FORM

Today's Date: _____ Your Name: _____

Date of Birth:_____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Alternative Phone #:_____

Email: _____

We will email or text a reminder 24 hours before your appointment.

In case of emergency: _____ Phone: _____

Physician:_____ Phone: _____

How did you hear about us or who referred you? _____

Health Insurance Claim Form Information:

If you have "out of network" coverage with your insurance, we can provide you with a Health Insurance Claim Form (HICF) for reimbursement. To find out if you have "out of network" benefits, please call the number on the back of your insurance card.

If you are requesting reimbursement forms we will need a copy of your insurance card. Our front desk staff will be happy to help you with this. If the policy holder is different than yourself, please provide their name and birth date below:

Policy Holder's Name: _____ Date of Birth:_____