

CARL L. POTTER, III LCSW

Intake Form

Date: _____

Patient Information-PLEASE PRINT

Last Name _____ First Name _____ MI _____

Sex: Male _____ Female _____ Nickname _____

Street Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Date of Birth _____ Social Security # _____

Marital Status: Married _____ Single _____ Seperated _____ Divorced _____ Widowed _____

Student Status: Full Time _____ Part Time _____ School _____ Not a Student _____

Employment: Full Time _____ Part Time _____ Employer Name _____ Not working _____

**THE FOLLOWING INFORMATION MUST BE COMPLETED FOR CORRECT BILLING
Who is responsible for Co-pays and Deductibles: COMPLETE NAME / ADDRESS**

Primary Insurance Coverage - PLEASE DO NOT LEAVE ANY BLANKS

Insurance Co _____ Managed Care Co. _____

Claims Address _____ City _____ State _____ Zip _____

Policy# _____ Group# _____ Tel#() _____

Please present your card to therapist to be photocopied

