Selah
Wellness & Therapeutic Services, LLC

PATIENT INTAKE FORM

Provider: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ □ Male □ Female

Age: ____ Date of Birth: _____ Social Security Number: _____

Address: _____ Phone: (H) (W) (C) _____

_____ Email: _____

City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION:

Please check one: □ PRIMARY □ SECONDARY □ EAP □ SELF-PAY

Insurance Carrier: _____ Phone #:_____

Policy ID#: _____ Group #: _____

Policy Holder: _____ Relation: _____ Date of Birth: _____

Please check one (if applicable): □ PRIMARY □ SECONDARY

Insurance Carrier: _____ Phone #: _____

Policy ID#: _____ Group #: _____

Policy Holder: _____Relation: _____ Date of Birth: _____

EMERGENCY CONTACT:

Contact Person: _____ Relation: _____

Contact Number(s): (H) (W) (C) _____ (H) (W) (C) _____

Patient Signature: _____ ***Date***: _____

9500 Medical Center Drive, Suite #440-E, Largo, MD 20774 ~ (301) 875-5680 ~ sharonlawrence@myselahwellness.com