112 Lake Street, Burlington VT
Fax: 802-859-3309

ADULT INTAKE FORM

Please note: Missing information may delay the referral process.

Date:_____

Last Name: _____ First Name: _____

Address: _____
Street City State ZIP

(H) Tel: _____ (C) Tel: _____ (W) Tel:_____

OK for Message? Home_____ Work_____ Cellular_____

Email: _____

Sex: M/F_____ Current Age:_____ DOB:_____ SSN: _____

Referred By: _____ PCP: _____ Location:_____

To Make an Appt. Contact: _____ Telephone: _____

Current Medication: _____

Current Diagnosis (if applicable): _____

Reason for Referral:_____

_____

_____

INSURANCE/BILLING INFORMATION

Insurance:_____ Tele: _____

Policy ID#: _____ GRP#: _____

Employer: _____ Secondary Insurance:_____

Subscriber: _____ SSN: _____

Please fax back to Vermont Center for Anxiety Care @ 802-859-3309. Thank you.