

Community Rehabilitation Services of Oregon  
CLIENT INTAKE

<b>CLIENT INFORMATION :</b>		<b>REFERRAL DATE :</b>
NAME:	BIRTH DATE:	
ADDRESS:	PHONE: H	
CITY/STATE/ZIP:	SOC. SEC. #:	
FAMILY/CONTACT:	PHONE:	
<b>REFERRAL / PHYSICIAN INFORMATION :</b>		
REFERRAL SOURCE:	PHONE:	
ADDRESS:		
PRIMARY MD:	PHONE:	
ADDRESS:		
ICD 9 DIAGNOSIS:	ICD 9 CODE:	
<b>FUNDING / INSURANCE INFORMATION :</b>		
PRIVATE PAY (list who will receive the bill)		
NAME:	PHONE:	
ADDRESS:		
COMMENTS:		
NAME OF INSURANCE CO:	POLICY HOLDER:	
POLICY/ID OR CLAIM #:	GROUP #:	
ADDRESS:		
CONTACT PERSON / ADJUSTER:	PHONE:	
DATE CALLED / COMMENTS:		