**OT by Roni Casser**

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Insurance Intake Information

**Patient Information**

|  |  |
| --- | --- |
| Patient Name |  |
| Date of Birth |  |
| Address |  |
| City, State ,Zip |  |
| Home Phone |  |
| Cell Phone |  |

**Insurance Information**

|  |  |
| --- | --- |
| Insurance Company |  |
| ID# |  |
| Name of Insured |  |
| Group# |  |
| Member Service Phone # |  |
| Relation to Insured |  |