Tranquil Innovations, LLC

Patient Intake & Insurance Questionnaire

Complete all applicable sections. Return through secure email or portal whenever possible. If standard email is used, do so only after the patient is informed of privacy risks.

A. Office Use Only

Intake date | Staff reviewer | MRN / chart # | Eligibility verified ☐ Yes ☐ No

B. Patient Information

Full legal name * | Preferred name | Date of birth * | Age

Street address * | Apartment / Unit | ZIP *

City * | State * | Preferred language | Interpreter needed ☐ Yes ☐ No

Cell phone * | Home phone | Email *

Sex assigned at birth | Gender identity | Pronouns | Last 4 of SSN

C. Contact Preferences

Preferred contact method: ☐ Call ☐ Text ☐ Email ☐ Portal

OK to leave voicemail? ☐ Yes ☐ No

Best days / times to reach patient | Referral source / how patient heard about us

D. Emergency Contact

Name * | Relationship * | Phone *

Please enter insurance information exactly as it appears on the card. A copy of the front and back of the card should be collected separately when possible.

E. Primary Insurance Information

Insurance company / payer *

Plan name / product

Behavioral health phone

Member / policy ID *

Group #

Copay / coinsurance (if known)

Deductible met? ☐ Yes ☐ No

Subscriber name *

Subscriber DOB

Relationship to patient *

Employer

Subscriber address (if different from patient)

Claims mailing address

F. Secondary Insurance Information

Insurance company / payer

Plan name / product

Behavioral health phone

Member / policy ID

Group #

Subscriber name

Subscriber DOB

G. Financially Responsible Party (if different from patient)

Name

Relationship to patient

Phone

Address

H. Insurance Card Collection

Office note: front of card obtained ☐ Yes ☐ No back of card obtained ☐ Yes ☐ No

Use the office use section or internal workflow to document real-time eligibility checks, authorization requirements, and payer-specific intake instructions.

I. Presenting Concerns

What brings you in for services at this time? *

Primary goals for treatment / services

J. Current Symptoms / Areas of Concern

- [ ] Anxiety
- [ ] Depression
- [ ] Trauma / PTSD
- [ ] Grief / loss
- [ ] Stress / burnout
- [ ] Panic
- [ ] Sleep problems
- [ ] Attention / focus
- [ ] Mood swings
- [ ] Relationship / family stress
- [ ] Substance use concern
- [ ] Other

How long have symptoms been present?

Severity (mild / moderate / severe)

Any recent triggering events?

K. Current Providers, Medical History, Medications

Primary care provider

Psychiatrist / prescriber

Current therapist / counselor

Current medical conditions / diagnoses

Allergies / medication reactions

Current medications (name, dose, reason, prescribing provider)

Recent hospitalizations / ER visits / major medical events

L. Behavioral Health and Substance Use History

Prior outpatient counseling / therapy	☐ Yes	☐ No	Details / dates / provider
Prior psychiatric evaluation or medication management	☐ Yes	☐ No	Details / dates / provider
Prior psychiatric hospitalization	☐ Yes	☐ No	Details / dates / provider
Prior substance use treatment	☐ Yes	☐ No	Details / dates / provider

Current alcohol, nicotine, cannabis, or other substance use (type / frequency / amount)

M. Safety Screening

Current thoughts of self-harm or suicide	☐ Yes	☐ No	If yes, details
History of suicide attempt or self-injury	☐ Yes	☐ No	If yes, details
Current thoughts of harming someone else	☐ Yes	☐ No	If yes, details
Feeling unsafe at home / in relationship	☐ Yes	☐ No	If yes, details
Access to weapons or other lethal means	☐ Yes	☐ No	If yes, details

If the patient reports an immediate safety concern, activate your urgent response workflow. For crisis help, call or text 988 or call 911.

N. Social / Functional Needs (optional but recommended)

☐ Housing ☐ Food insecurity ☐ Transportation ☐ Employment / school

☐ Finances ☐ Caregiving stress ☐ Legal / court ☐ Other

Additional context patient wants the care team to know

O. Communication and Privacy Preferences

Preferred pharmacy

Pharmacy phone

Preferred appointment times

May we contact the patient by: ☐ Phone ☐ Voicemail ☐ Text ☐ Email ☐ Portal

People with whom we may speak about appointments / billing / care coordination (name + relationship), if authorized

P. Patient Acknowledgments

☐ I certify that the information provided on this form is true and complete to the best of my knowledge.

☐ I understand that insurance benefits quoted or estimated are not a guarantee of payment and that I remain responsible for amounts not paid by my health plan, subject to applicable law and payer contract terms.

☐ I authorize the release of information necessary to obtain payment for services and assign insurance benefits, where permitted, to the treating provider or practice.

☐ I understand that electronic communication, including standard email, may involve some privacy risk. If I request or continue to use standard email, I accept that risk after being informed.

Q. Signature

Patient / legal representative name

Relationship if not self

Date

Typed signature / acknowledgment

Staff witness / received by

R. Office Follow-Up

Appointment scheduled ☐ Yes ☐ No

Clinician / program

Date / time