Wellspring Farm Learning Center & Wellspring On The Harbor

INTAKE FORM DATE: _____

NAME: _____

DOB: _____

DIAGNOSIS: _____

PARENT/GUARDIAN (if applicable): _____

ADDRESS: _____

_____

PHONE: _____

PRIMARY INSURANCE/POLICY # : _____

POLICY HOLDER NAME & DOB: _____

SECONDARY INS. (MASS HEALTH #): _____

REFERRAL SOURCE: _____

PHONE: _____

For your own privacy or the privacy of your client/patient and in compliance with HIPAA laws, please print this intake form and either fax or mail it to:

Wellspring Farm Learning Center

FAX - 1-888-577-9425 **MAIL - 42 Hiller Road, Rochester, MA 02770**

NOTES: _____

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