

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date _____ Patient Name _____
FIRST M LAST

SSN _____ Male Female DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient's employer _____ Full time Part time Retired Work phone _____

Spouse or Parent's Name _____ Phone _____

Emergency contact _____ Phone _____

*Referring Source Name _____ Phone _____

Responsible Party (Party other than patient who is Legally Responsible For Payment of Services)

Name of responsible party _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

SSN# _____ DOB _____ Single Married Divorced Widowed Separated

Employer _____ Full time Part time Retired Work phone _____

***(Please fully complete this section) Insurance Information**

Name of the insured person (card holder) _____ Relationship to patient _____

Address _____ City, State, Zip _____

Phone _____ Birthdate _____ SSN _____

Name of employer _____ Full time Part time Retired Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance Company Name _____ ID# _____ Group# _____

Ins. Co. address _____ City _____ State _____ Zip _____

****Do you have Secondary Insurance Yes No If yes, please let front desk know**

I authorize release of any information concerning my (or child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I agree to pay for services rendered, and those not covered by insurance. My signature also certifies that the above information is correct.

X _____
Signature of patient or parent if minor

X _____
Date

OFFICE USE ONLY: Therapist/Doctor _____ *Primary DX _____