

Today's date: _____ Reason for your visit: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Mr. Miss Mrs. Ms. Marital status (circle one)
 _____ Mrs. Ms. Single / Mar / Div / Sep / Wid

Is this your legal name? Yes No If not, what is your legal name? _____ (Former name): _____ Birth date: _____ Age: _____ Sex: _____
 _____ / / _____ M F

Street address: _____ Social Security no.: _____ Cell phone no.: _____ Home Phone no.: _____

City: _____ State: _____ ZIP Code: _____

Preferred method of contact? _____ May we leave a message? _____

Occupation: _____ Employer: _____ Employer phone no.: _____
 _____ ()

Chose clinic because/Referred to clinic by (please check one box): Dr. Insurance Plan Hospital
 Family Friend Close to home/work Yellow Pages Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Home phone no.: _____
 _____ / / _____ ()

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____
 _____ ()

Is this patient covered by insurance? Yes No

Please indicate primary insurance

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: _____ Group no.: _____ Policy no.: _____ Co-payment: _____
 _____ / / _____ \$

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: _____ Cell phone no.: _____
 _____ () ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

 Patient/Guardian signature _____ Date