

PATIENT INFORMATION

Today's Date _____

Full Name _____ Title (Mr., Jr., Rev, etc) _____

Street Address: _____ Apt. # _____

City _____ State _____ Zip _____ Home Tel _____

Cell Phone _____ Other _____

SS# _____ - _____ - _____ Date of Birth ____/____/____ Sex _____ Marital Status _____

Spouse Name _____ Spouse Date of Birth ____/____/____

Who referred you to our office? _____

Who is your Primary Care Physician? _____ Phone Number _____

Name and telephone # of someone to contact in case of emergency: _____

May we contact you at your work # to confirm or cancel appointments? _____

EMPLOYMENT

Occupation _____ Employer _____

Telephone # _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Full Name _____ Relation: _____

Street Address: _____ Apt. # _____

City _____ State _____ Zip _____ Home Tel _____

SS# _____ - _____ - _____ Employer Telephone # _____

INSURANCE INFORMATION: We will file your insurance for you as a convenience; however, **you are responsible at the time of service for any deductibles, co-pays, and services that your insurance does not cover.** It is your responsibility to be aware of the benefits that your insurance provides. **It is the patient/responsible party's responsibility to obtain a valid referral/authorization prior to the initial appointment from the insurance company if one is required.** If there is no authorization, and one is required by your insurance company, any unauthorized sessions will become the responsibility of the patient/responsible party.

Does your insurance company require pre-certification/authorization for mental health benefits? _____

Primary Insurance Company _____ Employer _____

Policy Number _____ Group # _____

Policy Holder's Name _____ Relation to Patient _____

Policy Holder's SS# _____ Policy Holders' Date of Birth _____

Telephone # to verify benefits _____

Please give the receptionist your insurance card(s) to copy

Secondary Insurance Company _____ Employer _____

Policy Number _____ Group # _____

Policy Holder's Name _____ Relation to Patient _____

Policy Holder's SS# _____ Policy Holders' Date of Birth _____

Telephone # to verify benefits _____