PATIENT INFORMATION **PLEASE PRINT**

DATE: _____

Name of PATIENT: _____

Address of PATIENT: _____

CITY: _____ STATE: _____ ZIP: _____

Date of Birth of PATIENT: ____/____/____

Phone Number(s) of PATIENT:

Home (___)_____ Work (___)_____ Cell (___)_____

THIS PORTION TO BE FILLED OUT ONLY IF USING INSURANCE

RELATIONSHIP OF SUBSCRIBER* TO PATIENT: (CIRCLE ONE)

Subscriber is the person to whom the insurance is under

SELF SPOUSE CHILD PARENT OTHER

SUBSCRIBER INFORMATION (IF DIFFERENT FROM PATIENT)

Name of SUBSCRIBER: _____

Address of SUBSCRIBER: _____

CITY: _____ STATE: _____ ZIP: _____

Date of Birth of SUBSCRIBER: ____/____/____ **(MUST HAVE)**

EMPLOYER OF SUBSCRIBER: _____

INSURANCE INFORMATION:

NAME OF INSURANCE: _____

INSURANCE ID NUMBER ON CARD: _____

GROUP NUMBER ON INSURANCE CARD: _____

CUSTOMER SERVICE PHONE # ON BACK OF CARD: (____)_____

CLIENT SIGNATURE: _____

Internal Use Only:

Benefits _____

Authorization Number & Number of Sessions _____

CPT _____ DSM _____

New clients must have this form filled out completely