

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ / ____ / ____ Age: ____ SSN# ____ - ____ - ____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Gender: Male ____ Female ____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Employment Status: Full-Time ____ Part-Time ____ Student ____ Unemployed ____ Disabled ____ Other ____

Employer: _____ Position/Occupation: _____

Referral source: _____

Primary Insurance: _____

Group # _____ Policy/ID # _____

Insurance Claim Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's SSN# ____ - ____ - ____ Insured's Date of Birth: ____ / ____ / ____

Policy Effective Date: _____ Phone # of insurance company _____

Primary Care Physician: _____ Phone # _____

Do you want information released to your doctor? Yes ____ No ____

If yes, please provide complete address: _____

Emergency Contact: _____

Phone # _____ Relationship to Patient: _____

Release of information and Assignment of benefits: I authorize the release of medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned therapist who accepts assignment for services.

Patient (or Guardian) Signature: _____ Date: _____