INFORMATION SHEET

PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

_____

Home Phone: _____

Birthdate: _____

Soc. Sec. #: _____

Emergency Contact: _____

Phone #: _____

Employer: _____

School/Grade: _____

Work Phone: _____

Occupation: _____

Relationship to Insured: _____

Marital Status: Married ☐ Sep ☐ Div ☐ Widow ☐ Single ☐ Co-Habit ☐

PRIMARY INSURANCE INFORMATION

☐ self ☐ parent ☐ spouse ☐ guardian

Name _____
Last First M.I.

Address _____
(if different)

_____

Home Phone _____
(if different)

Birthdate _____

Soc. Sec. # _____

Insured's Employer _____

Work Phone (____)_____

Insurance Co _____

Plan Name _____

Insured's ID # _____

Policy Group # _____

RESPONSIBLE PARTY/SECONDARY INSURANCE

☐ self ☐ parent ☐ spouse ☐ guardian

Insured's Name _____
Last First M.I.

Address: _____
(if different)

_____

Home Phone: _____
(if different)

Birthdate: _____

Soc. Sec. #: _____

Insured's Employer _____

Work Phone (____)_____

Insurance Co. _____

Plan Name _____

Insured's ID # _____

Policy Group # _____

Authorization to Release Information: I authorize the release of any medical or other information necessary to process Insurance claims.

_____
Signature Date

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____
Signature Date