PATIENT GENERAL INFORMATION

Last Name:____

First Name:_____________________________ Middle Initial:_____________

Date of Birth:___________________________Gender: F M Other

Relationship Status: Single Married Domestic Partners Divorced Other

Employment Status: Employed Full-Time Student Part-Time Student Other

Email Address:____
(Your Statement and Bill will be sent to this email address)

Address:_______________________Apt:______City:_________ Zip:________ State:__

Home Phone:_________________ Work Phone:______________Cell:_____________
OK to leave message on Phone? Yes No Which number to leave msgs?_________

Emergency Contact (name & number):_______________________________________

Other Responsible Party (who pays the bill?):__________________________________

Responsible Party Street Address:____

Responsible Party City, State & Zip:____

IF INSURANCE WILL BE USED, FILL IN THIS SECTION:

Primary Insurance Company____

Insurance ID Number:_________________Group Number:________________________

Effective Date:________________ Referral Source:_____________________________

Patient's Relationship to Insured: Self Spouse / Domestic Partner Child Other

Insured's Name (Insurance Policy Holder): Last:____________First:_______Middle:__

Insured's Address:____

Insured's City:___________________________State:_______Zip:_________________

Insured's Date of Birth:____________ Insured's Gender: ___________

Insured's Employer:____

Annual Deductible $:____________________Deductible Met $:_____________________

Pays at:______________________________Usual Fee or Copay $:_________________

Visit Limit: ____________________________(Visits are based on "Medical Necessity")

Pre-Authorization Required?: Yes No

Pre-Auth By Whom?:____

Pre-Auth Phone Number:____

Authorization Number:___________________Sessions Left in Authorization:___________

Authorization Start Date:_________________Authorization End Date:________________

Spoke with (Benefits):____

Spoke with (PreAuth):____

Secondary Insurance Company:_______________________________________

Secondary Authorization Number:_____________________________________

Other Insured Name: Last:__________________First:_____________Middle:_________

Other Insured's Gender: _____ Other Insured's Date of Birth:_____________________

Other Insured's Policy or Group Number:_______________________________

Other Insured's
Employer:____

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of medical benefits to my provider for services rendered.

____ ____________________

Signature of Subscriber or Beneficiary Date