PATIENT INFORMATION SHEET

Client's Name: _____ DOB: _____

Parent Name (if other than insured): _____

Parent Phone Numbers: H: _____W:_____ C:_____

Other Numbers (if needed): _____

Address: _____

City: _____ Zip: _____

Insured's Name _____

Insured's DOB:_____

Insured's ID or Policy# _____Group #_____

Insured's Employer: _____

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Co. Phone number(s): _____

_____

Do you know what your deductible is? _____

Have you met this deductible? _____

What is your copay amount?_____

Physician's Name:_____ Phone Number:_____

Referral # (if applicable): _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim with my insurance company.

Signed: _____ Date: _____