For office use only: DX _____

PATIENT DEMOGRAPHICS & INSURANCE FORM

Name:_____ Date of Birth: _____

Street _____

City:_____ _____ State:_____ Zip:_____

Cell: _____ Home Tel:_____ Work: _____

Sex: _____ Social Security No:_____ Email address: _____

EMERGENCY CONTACTS

Spouse's/Other Name:_____ Phone:_____

RESPONSIBLE PARTY (if other than patient) name, address and phone:_____

_____

PRIMARY INSURANCE *attach copy of card

Primary Insurance: _____

Insurance Address: _____

Ins telephone # for mental health providers: _____

Name of Subscriber:_____.Subscriber's date of birth: _____

Policy ID. _____Group No. _____Relationship to patient_____

SECONDARY INSURANCE * attach copy of card

Secondary Insurance : _____Name of Subscriber:_____

Insurance Co. Address : _____

Policy ID _____ Group No. _____

I _____in consider of any medical or psychiatric services provided, or in consideration of credit extended in the performance of such services, do hereby assign any insurance benefits covering such services to which I may be entitled to the undersigned provider. I further understand that I remain financially responsible for the balance of such services not covered under my insurance policy.

I also authorize the release of any medical information necessary for any of insurance benefits as assigned above or for the processing of any claim for insurance benefits for services provided by .

_____ _____

SIGNATURE Date