Patient Information

Name: Last: ______________________________ First: ________________________ Middle Initial: _____

Date of Birth: _____/_____/_____ Social Security Number: _______/_____/_________ Sex (M/F): ______

Home Address: ____________________________________ City: __________________ Zip Code: __________

Home Phone: (_____)_______-___________ Work Phone: (_______)_______-___________

Occupation: ______________________________________ Employer: ________________________________

Covered Employee Information (if different from above) or **Parent/Legal Guardian**:

Name: Last: ______________________________ First: ________________________ Middle Initial: _____

Date of Birth: _____/_____/_____ Social Security Number: _______/_____/_________ Sex (M/F): ______

Home Address: ____________________________________ City: __________________ Zip Code: __________

Home Phone: (_____)_______-___________ Work Phone: (_______)_______-___________

Occupation: _____________________________ Employer: ______________________________

Insurance & Other Information

Health Plan Name: ______________________________ Patient's ID Number: __________________________

Patient's Current **Primary Physician**: ___________________ Tel: (____)____-________ Fax: (____)____-________

Street Address (w/ zip code): ____

Date of Last Physician Visit: ____/____/____ Reason: ___________________________________

Patient's Current **Psychiatrist**, if any: ___________________ Tel: (____)____-________ Fax: (____)____-________

Street Address (w/ zip code): ____

Referred By: ____________________________________ Tel: (____)____-________

Emergency Contact Name: _________________________ Tel: (____)____-________

I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in this information.

_______________________________________ ________________________________ ____________

Insured, Parent, Guardian, or Responsible Party Patients Signature, if different Date

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Office Use Only below this Point

Auth. #: ______________________ Auth. Period: ____-___-____ to ____-____ -____ #visits auth.: ______

Diagnosis Code:________________ Co-Pay/Deductible: _______ Network Tel #: ______-______-__________

(ed. *04/06)*