PATIENT INFORMATION

DATE_______________

PATIENT NAME____ DATE OF BIRTH_______________

STREET____ CITY_______________ ST_____ ZIP__________

SEX_____ MARITAL STATUS__________ SS#_____________________ EMPLOYER____________________

HOME PHONE____________________ WORK PHONE____________________ CELL____________________

EMAIL___________________________________ REFERRED BY_________________________________

FINANCIAL RESPONSIBILITY

NAME____ RELATIONSHIP TO PATIENT_______________

STREET____ CITY_______________ ST_____ ZIP__________

HOME PHONE____________________ WORK PHONE____________________ CELL____________________

INSURANCE INFORMATION

NAME OF INSURED____________________________________ RELATIONSHIP TO PATIENT_______________

INSURED'S D.O.B.______________ EMPLOYER________________________ PHONE____________________

NAME OF INSURANCE CARRIER_____________________________________ PHONE ____________________

ADDRESS____ CITY_______________ ST_____ ZIP__________

SS# OF INSURED___________________ POLICY ID#__________________________ GROUP #_____________

IF SECONDARY INSURANCE IS AVAILABLE, PLEASE COMPLETE BELOW

NAME OF INSURED____________________________________ RELATIONSHIP TO PATIENT_______________

INSURED'S D.O.B.____________ EMPLOYER___________________________ PHONE____________________

NAME OF INSURANCE CARRIER_____________________________________ PHONE ____________________

ADDRESS____ CITY_______________ ST_____ ZIP__________

SS# OF INSURED___________________ POLICY ID#__________________________ GROUP #_____________

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim:

Signature of patient or parent/guardian____ Date_______________

I authorize payment of medical benefits directly to the provider:

Signature of patient or parent/guardian____ Date_______________

FOR OFFICE USE ONLY

THERAPIST:____ DIAGNOSIS CODE 1:____________ 2:____________