Patient Information

(To be completed again after a 6 month lapse in treatment)

Patient Name	Street Address	City, State & Zip	Day Phone	Evening Phone

Patient Date of Birth	Patient Social Security Number	Patient Driver License Number

Who my we contact in an emergency?
Name: **Address:** **Phone:** **Relationship:**

Insurance Information

Primary Insurance Co:	ID#	Group #
Address:	**City, State, Zip**	
Primary Insured's Name	**Primary Insured's Employer**	
Primary Insured's Social Security #	**Primary Insured's Date of Birth**	

Secondary Insurance Co:	ID#	Group #
Address:	**City, State, Zip**	
Secondary Insured's Name	**Secondary Insured's Employer**	
Secondary Insured's Social Security #	**Secondary Insured's Date of Birth**	

IF YOU WISH US TO BILL YOUR INSURANCE, PLEASE SIGN BELOW

I authorize release of information to my insurance company for payment

I authorize assignment of benefits to be paid to the provider

_____ _____ _____

Signature (If client is a minor, adult must sign) **Relationship** **Date**