PATIENT INFORMATION SHEET

Court Ordered? YES NO Program: _____

PATIENT

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Date of Birth: _____/_____/_____ Age: _____ SS#: _____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone #: _____ Is the client Court Ordered? _____

INSURANCE We need a front/back copy of your card(s) for our records.

Primary

Insurance Company: _____ Phone # : ( ) _____

Insured's Name: _____ ID/Policy #: _____

Insured's DOB: _____ Group # _____

Secondary

Insurance Company: _____ Phone # : ( ) _____

Insured's Name: _____ ID/Policy #: _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill

Responsible Party: _____ Relation to Patient: _____

SS#: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City/State: _____ Zip: _____

Mailing Address: _____ City/State: _____ Zip: _____

Employer Name: _____ Occupation: _____

Monthly Household Income: _____

SIGNATURE (Patient, Parent, Legal Guardian or Responsible Party) **Release of Information Signed?** YES NO

I request Services X _____ Date: _____

PAYMENT METHOD: Cash Credit Card Check

Credit Card Information

Name on Card:_____ Card Number: _____

Expiration Date: _____ CVC Code: _____ Amount: _____
