PERSONAL INFORMATION

Date_____

First Name _____ Date of Birth ____/_____/____ Age _____ ☐Male ☐ Female

Last Name _____ Social Security Number _____-_____-_____

Address _____ _____ _____
Street City, State, Zip

Home Phone ( ) - _____ - _____ ☐Single ☐Married ☐Other

Work Phone ( ) - _____ - _____ ☐ Employed ☐Student

Cell Phone ( ) - _____-_____

email _____ Are email/voicemail systems confidential? ☐ yes ☐ no

Responsible Person (if other than patient)_____ Relationship _____

Learned about services from: ☐ Professional (Name:_____)
☐ Friend or Relative (Name:_____)
☐Yellow Pages
☐Other_____

INSURANCE INFORMATION

Insured's Plan ID number _____ Insured's Name _____

Patient's relationship to insured ☐self ☐spouse ☐ child Plan Group #_____

Social Security Number of Insured _____-_____-_____

Insured Date of Birth _____/_____/_____ Insurance Verification Telephone # ( )-_____-_____

Employer _____ Insurance Plan Name _____

FOR OFFICE USE ONLY

☐ Are benefits managed? Yes NO By: _____( )-_____-_____

☐ authorization number #_____ for _____ visits ☐ ECS # _____

☐_____ visits per year ☐ $_____ cal yr max ☐ $_____ deductible ☐ ($_____ met)

☐ Insurance pays $_____ per visit or _____% $____ co-pay/patient responsibility per visit

☐ Testing covered at %_____.

☐ modalities covered: 90801 90806 90847 96100 96117 ☐ Restrictions?

☐ Address to send claims: _____ _____ _____
Street City, State, Zip