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GENERAL INFORMATION:

Your First Name __________________________ MI _______ *Your* Last Name ____________________________

Street Address __________________________ Town/City: _____________________ State _____ Zip _________

Phone Numbers Land-line (_______)______________________ Cell (_______)_________________________

Your Date of Birth __________________________ *Your* Social Security # _________________________________

Email address ____

INSURANCE / INSURER INFORMATION:

PRIMARY HEALTH INSURANCE -

Policy Holder's name:__________________________________ Circle: M or F

Relationship to patient:_________________________________ Group #:______________________________
(self, spouse, child)

Insurance Co.:____ Phone #: for benefits:_____________________

ID# of patient:___________________________________ SS# of policyholder:___________________________

ID# of the policyholder (if different): _____________________________ DOB of policyholder: ______________

SECONDARY HEALTH INSURANCE (if any) –

Policy Holder's name:__________________________________ Circle: M or F

Relationship to patient:_________________________________ Group #:______________________________
(self, spouse, child)

Insurance Co.:____ Phone #: for benefits:_____________________

ID# of patient:___________________________________ SS# of policyholder:___________________________

ID# of the policyholder (if different): _____________________________ DOB of policyholder: ______________

If your insurance company requires an authorization to pay for your visits, please call your insurance to request an authorization and authorization number. Please note that some insurance companies no longer "backdate" authorizations. Therefore, if your visits aren't authorized prior to your visit, the company may not pay!

Authorization #: ____ # of visits authorized:___________

Date started:_________________________________ Date ends: ___________________________________