Patient Information Sheet

Date______________

Name of Patient: ____

Address____

City________________________ State: ____________ Zip: ________

Phone: Home: ______________ Work: ______________ Cell: ______________

E-mail: ____

Date of Birth: ______________. Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Status: ☐ Single ☐ Married ☐ Other

☐ Male. ☐ Female ☐ Nonbinary

☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Insured's Name: ____
(if you, the client are also the insured, write: Same as Above. If you, the client are not the insured, please fill in)

Address: ____

City: ________________________ State: ______________ Zip: ________

Phone: Home: ______________ Work: ______________ Cell: ______________

Date of Birth: ____________________

Insurance Company: ____

Insurance Company Address: ________________________________
(from back of Insurance Card)

City: ________________________State: ______________Zip: ________

Insurance Company Phone: ______________Insured's Employer: ______________

Insurance ID#:____

Group/Policy #: ____

Secondary Insurance (if applicable):

Insured's Name: ______________________________
(if you, the client are also the insured, write: Same as Above. If you, the client are not the insured, please fill in)

Address: ______________________________

City: ______________ State: ______________ Zip: ________

Phone: Home: ______________ Work: ______________ Cell: ______________

Date of Birth: ______________

Insurance Company: ______________________________

Insurance Company Address: ______________________________
(from back of Insurance Card)

City: ______________ State: ______________ Zip: ________

Insurance Company Phone: ______________ Insured's Employer: ______________

Insurance ID#: ______________________________

Group/Policy #: ______________________________