

[Your Practice Name]

## CLIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street, City, Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ OK to call? \_\_\_\_\_ Social Security #: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ OK to call? \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ Reason: \_\_\_\_\_

### *In Case of Emergency Contact:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street, City, Zip: \_\_\_\_\_ Phone : \_\_\_\_\_

### *Person Responsible for the Bill:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street, City, Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Week Day Phone: \_\_\_\_\_ Week End/Night Phone: \_\_\_\_\_

You may release information necessary for billing to this person: \_\_\_\_\_

### *Primary Insurance Plan:*

Name of Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address for Claims: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Group Number or Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

CoPay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Deductible Left: \_\_\_\_\_ Yearly Max: \_\_\_\_\_

### *Secondary Insurance Plan:*

Name of Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Group Number or Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

CoPay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Deductible Left: \_\_\_\_\_ Yearly Max: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please indicate how best to contact you: \_\_\_\_\_