Date: ___________________

PLEASE PRINT

# CONFIDENTIAL PATIENT INFORMATION FORM

Name: ______________________________________________________________________________
First Middle Last

Address: ____________________________________________________________________________
Number Street City State Zip

Mailing Address: ______________________________________________________________________
(If Different) Number Street City State Zip

Home Phone: ( ) _________________ Work Phone: ( ) ________________ Cell Phone: ( ) _________________

Soc. Sec. No: ________________________ Date of Birth: __________________Email: _________________________

Gender: ☐Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other _____________

Employer: ____________________________________________________ Full Time Part Time

Student: ☐ Full Time ☐ Part Time Referred by: _________________________OK to Acknowledge Referral? ☐ Yes ☐ No

## INSURANCE INFORMAITON

**Primary Insurance Carrier**: _____________________________________________ Ins. Phone # ________________

Address: _____________________________________________________________________________________

***Policyholder:***

Name: ______________________________Date of Birth: __________________ Soc. Sec.No.: __________________

Address: _______________________________________________________________ Gender: ☐ Male ☐ Female

Home Phone: ( ) __________________ Work Phone: ( ) ____________________Cell Phone: ( ) ______________

Employer: __________________________________________ Email: ______________________________________

Policy/ID Number: _________________________________ Group No.: ___________________________________

Relationship of patient to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________________________

**Secondary Insurance Carrier**: ___________________________________________ Ins. Phone # ________________

Address: _____________________________________________________________________________________

***Policyholder:***

Name: ______________________________Date of Birth: __________________ Soc. Sec.No.: __________________

Address: _______________________________________________________________ Gender: ☐ Male ☐ Female

Home Phone: ( ) __________________ Work Phone: ( ) ____________________Cell Phone: ( ) ______________

Employer: __________________________________________ Email: ______________________________________

Policy/ID Number: _________________________________ Group No.: ___________________________________

Relationship of patient to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________________________

## RESPONSIBLE PARTY INFORMATION

**Person Responsible for Payment (if other than patient)**

Name: _________________________________________ Check if: ☐ Custodial Parent ☐ Legal Guardian

Address: ______________________________________________________________________________

Home Phone: ( ) _________________ Work Phone: ( ) ________________ Cell Phone: ( ) _________________

Relationship to patient**: _________________________** **Email: ______________________**

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits to myself or to the party who accepts assignment below:**

**SIGNED: ____________________________________________ Date: __________________________________**

**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE" I authorize payment of medical benefits to Conna J. Corbett, LCSW for all services provided**

**SIGNED: _________________________________________________ Date: _____________________________________**

**FOR OFFICE USE ONLY: Dx: ______ Copay: ____ Fee: (for 90801) ______ (90806)_______ New Patient yes no**
**Managed Care: Yes No # Sessions Auth'd _____ Start______________End ___________ Auth# __________________**