

Therapist Name:

1st Appointment Date:

Patient / Insurance Information Sheet

Name of patient: _____ Gender: _____

Street Address: _____

City, State, Zip: _____

Patient Phone: (H) _____ (W) _____

Patient's date of birth: _____ Patient's social security #: _____

Name of insured: _____ Gender: _____

Insured's Street Address: _____

Insured's City, State, Zip: _____

Patient's relationship to insured: _____ Insured's Date of Birth: _____

Insured's Social Security #: _____

Insurance Carrier: _____

Insurance Carrier Phone Number: _____

Insurance Carrier Address: _____

Employer and/or Group # of plan: _____

Insurance ID (if different from Social Security number): _____

Authorization Information:

(Enclose copy of authorization letter) **-OR-** 1. Number of sessions authorized: _____

2. Start & end dates: _____

3. Authorization number: _____