INTEGRATED
BEHAVIORAL
HEALTH
psychological services

PERSONAL INFORMATION

PLEASE PRINT CLEARLY

PATIENT:

Date of Birth:___/___/___ Gender: M F

Street Address:

City, State, Zip:

RESPONSIBLE PARTY:

Relationship to Patient: Self Parent Spouse Other

Responsible Party's SSN:

Street Address (if different):

City, State, Zip (if different):

Please indicate with an "" any phone numbers where we may **NOT** leave messages.*

Home Phone:

Work Phone:

Cell Phone:

Home Phone (if different):

Work Phone (if different):

Cell Phone (if different):

Email Address (please print clearly):

Emergency Contact:

Name_____ Phone Number Relationship

Referral Source:

Referral Reason:

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder's Name:

Policy Holder's Date of Birth:

Home Address (if different):

Insurance Company Name:

Member/Enrollee ID #:

Group #:

Insurance Company Phone #:

Employer Name:

Relationship to Patient:

SECONDARY INSURANCE

Policy Holder's Name:

Policy Holder's Date of Birth:

Home Address (if different):

Insurance Company Name:

Member/Enrollee ID #:

Group #:

Insurance Company Phone #:

Employer Name:

Relationship to Patient:

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Completed by:_____ Date:___/___/

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