

NEW PATIENT PACKET

I. CLIENT INFORMATION

Name _____ Date of Birth _____ Age _____

Address _____ Apt ____ City/St _____ Zip _____

Phones: (C) _____ (H) _____ (W) _____

Employer _____

II. BILLING INFORMATION

Insurance Carrier _____

Insurance Phone No. for Providers (see back of card) _____

Policy Holder (if different from yourself) _____

Date of Birth of Policy Holder (if different from yourself) _____

Policy/ Member ID (include letters and numbers) _____

Group No. _____

“I verify the accuracy of the above information and I authorize provider to bill my insurance on my behalf. If provider bills insurance on my behalf and I have not paid for the service in advance, I request that payment of services be made directly to the provider.”

Signature _____ Date _____