

(1) PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth _____ Age: _____ Sex: Male Female

Marital Status: Minor Single Married Divorced Widowed Other Social Security No. _____

Address: _____
Street or PO Box Apt No. City / State / Zip Code

Employer (if patient is a minor, provide parent's employer): _____

(2) PATIENT CONTACT INFORMATION

I prefer to be contacted at: Home Work Mobile

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Mobile Telephone: (_____) _____ Emergency Contact Name: _____

Relationship to patient _____ Telephone: (_____) _____

(3) PRIMARY INSURANCE INFORMATION (Please provide card for staff to copy)

I am not coverage by an insurance company (skip to section 5)

Insurance Company Name: _____ HMO PPO Other

Policy Number: _____ Group No. _____ Phone: (_____) _____

Subscribers Name: Same As Patient or _____ DOB: _____

SS No. _____ Relationship to Patient Spouse Parent Other _____

(4) SECONDARY INSURANCE INFORMATION (Please provide card for staff to copy)

Insurance Company Name: _____ HMO PPO Other

Policy Number: _____ Group No. _____ Phone: (_____) _____

Subscribers Name: Same As Patient or _____ DOB: _____ SS No. _____

Relationship to Patient Spouse Parent Other _____

(5) RESPONSIBLE PARTY if someone other than patient is responsible for balances, co-payments or deductibles

Please note this is not your insurance company Same as Patient

Name: _____ Date of Birth: _____

Relationship to Patient Spouse Parent Other _____

Address if different from patient _____

Telephone Numbers: Home: (_____) _____ Work (_____) _____

I authorize the release of medical information necessary to process this bill to my insurance company, and request payment of benefits to Behavioral Health & Substance Abuse Network, Inc. I acknowledge that I am financially responsible for payment whether or not covered by insurance or other organization.

Signature of Patient (Parent/Guardian if minor child)

Date