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: ____________________