

PATIENT INFORMATION

Patient Name: _____ Age: _____

Date of Birth: _____ Social Security #: _____ Sex: ___female___male

Marital Status: ___Single___Married___Partnered___Divorced___Widowed___Separated Grade: _____

Address: _____
Street City State Zip Code

Employer/School: _____ Occupation: _____

Phone: Home _____ Work _____ Cell _____

Spouse's Name: _____ Home Phone #: _____

Spouse's Employer: _____ Spouse's Occupation _____ Work Phone #: _____

PERSON RESPONSIBLE FOR PAYMENT (NOT Insurance Company)

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer: _____ Occupation: _____

COMPLETE IF PATIENT IS A MINOR

Mother's Name: _____ Social Security # _____

Address: _____
Street City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer: _____ Occupation: _____

Father's Name: _____ Social Security # _____

Address: _____
Street City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID# _____

Subscriber Name: _____ Group #: _____

Secondary Insurance: _____ ID# _____

Subscriber Name: _____ Group #: _____

Assignment of Benefits: I request that payment of authorized insurance benefits be made on behalf of Northwest Neurobehavioral Institute for any services furnished to me. I authorize any holder of protected health information about me to release to my insurance and it agents any information necessary to determine these benefits or the benefits payable for services.

Signature of Patient (age 13 or older) AND holder of insurance policy AND parent/legal guardian/representative Date