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: _____