PATIENT INFORMATION SHEET

Name of Client: ____

(If form is being filled out by parent, please use information pertaining to child who will be seen.)

Street: ____

City: ______________________ State: __________ Zip Code: ______________

Telephone: ______________________ Date of Birth: ______________

Relationship to client of person filling out form: __ Self __ Spouse __ Parent

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Primary Insurance: ____

Subscriber Name: ____

Relationship to subscriber of person covered by insurance: __ Self __ Spouse __ Child

Group Number: ____________ Membership Number: ______________________

Employer Name: ____

Secondary Insurance: ____

Subscriber Name: ____

Relationship to subscriber of person covered by insurance: __ Self __ Spouse __ Child

Group Number: ____________ Membership Number: ______________________

Employer Name: ____

Insurance Claim Processing Disclaimer

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to either myself or the party who accepts assignments below. I authorize payment of medical benefits to the undersigned healthcare provider for any services rendered. In order to process third party insurance claims more smoothly and effectively, I do hereby give permission to release my insurance information. Such information is to be released only for the purpose of filing health insurance claims to insurance companies and related agencies.

Name: ______________________ Date: ______________

South County Child and Family Consultants
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