Please Print And Complete All Entries

Patient Name (Last - First - Middle)	Date of Birth	Age	Marital Status

Address (Street - City - State - Zip)	Home Phone / Work Ph.

In case if emergency contact:	Name	Relationship	Work Phone #/ Home Ph.

Family Physician	Address	Phone #

Who is financially responsible for this bill?	Phone #

Whom may we thank for referring you to us?

Insurance Information

Primary Insurance Name	Phone Number	Address

Name of Insured	S. S. #	DOB	Name of Employer	Phone #

I. D. #	Group #	Relationship to Patient

Secondary Insurance Name	Phone #	Address

Name of Insured	S. S. #	DOB	Name of Employer	Phone #

I. D. #	Group #	Relationship to Patient

Insurance Information And Authorization

I, the undersigned certify that I (or my dependent) have insurance with ______________________________ and assign directly to Behavioral Medicine Associates all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________	______________________________	____________________
Responsible Party Signature	Relationship	Date