BALANCE

Center for Mental Health and Wellness

Patient Information Form

Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____ Sex: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Employer or School: _____ Full or Part Time: _____

Emergency Contact: _____ Phone: _____

Treatment related to employment? _____ Auto accident? _____ Other accident? _____

Referred by: _____

Insured Person Information

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Employer: _____

Patient's relationship to insured person: _____

Insurance Information

Insurance: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Address: _____ Phone: _____

City: _____ State: _____ Zip: _____