Client Record Form

L. Name_____ F. Name _____ M.I. _____
Address_____
City _____ State _____ Zip _____
Home Phone # (___)____-_____ Work # (___)_____-_____ Cell # (___) ____-_____
Social Security # ____ - ___ - _____ Birth Date _____/_____/_____
Married ____Yes ____No

Insurance Information

Ins. Co. Name _____
Policy ID # _____ Group # _____
Ins. Co. Address _____
City _____ State _____ Zip _____
Phone # (____) _____-_____ 800 # (____) _____-_____
Name on Policy L._____ F. _____ M.I. _____
Address_____
* (If different from above)
City _____ State ____ Zip _____ D.O.B. ____/____/_____
Home Phone # (____) _____-_____
* (If different from above)
Patient Relationship to Insured: _____Self ____Spouse _____Child _____Other
Employer or School Name _____

Emergency Point of Contact

Name_____ Relationship _____
Home Phone # (____) ____-_____ Work Phone # (____) ____-_____

Guardian Information

*(If different from above)
L. Name _____ F. Name _____ M.I._____

I understand that if my Insurance Company fails to pay, I'm responsible for payment of all bills.

Signature _____