

## PATIENT INFORMATION

PATIENT INFORMATION					
Patient's Last name:		First:	Middle:	Marital status:	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Former name:		Birth date: [Birthday]	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:		Home phone no.:		Cell phone no.:	
Occupation:		Employer:		Preferred contact method:	
Referred by:					
Current Medications:					
INSURANCE INFORMATION					
Occupation:		Employer:	Employer address: (optional)		Employer phone no:(optional)
Please indicate primary insurance:					
Subscriber's name:		Subscriber's S.S. no.:	Birth date: [Birthday]	Group no.:	Policy no.:
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.: Policy no.:
AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS					
<p>I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize payment to Mary Lou Tabers L.M.F.T of any insurance or health plan benefits otherwise payable to me, but not to exceed regular charges for services. I agree to assume financial responsibility for any changes not covered.</p> <p>I hereby authorize examination and other medical services deemed necessary. I hereby authorize the release of any information required by my insurance carrier for services furnished me in order to process claims on my behalf.</p> <p>I READ THE ABOVE CAREFULLY, UNDERSTAND ALL OF ITS CONTENTS AND SIGN MY NAME HEREUNDER AS AUTHORIZATION</p>					
<hr style="width: 100%;"/> Patient/Guardian signature			<hr style="width: 100%;"/> Date		