

PLEASE PRINT

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth: _____

First Middle Initial Last

Mailing Address: _____

Number Street City State Zip

Physical Address (if Different): _____

Number Street City State Zip

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

OK to Call? Yes No Yes No Yes No

OK to Leave Message? Yes No Yes No Yes No

Social Security #: _____ Sex: Male Female Email: _____

Marital Status: Single Married Divorced Separated Other _____

Employer: _____ Full Time Part Time

Student: Full Time Part Time Referred by: _____ OK to Acknowledge Referral? Yes No

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Ins. Phone #: _____

Address: _____

Policy Holder Information:

Relationship of patient to insured: Self Spouse Child Other _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ Sex: Male Female

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Email: _____

I.D. Number: _____ Social Security Number: _____ - _____ - _____

Group Number: _____

Secondary Insurance Carrier: _____ Ins. Phone #: _____

Address: _____

Policy Holder Information:

Relationship of patient to insured: Self Spouse Child Other _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ Sex: Male Female

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Email: _____

I.D. Number: _____ Social Security Number: _____ - _____ - _____

Group Number: _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Payment (If other than patient)

Name: _____ check if: Custodial Parent Legal Guardian

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Relationship to Patient: _____ Email: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims. I authorize payment of medical benefits to **Dr. Keith J. Andersen** for all services provided.

SIGNED: _____ DATE: _____

PROVIDER COMPLETE: ICD-Dx #1: _____ ICD-Dx #2: _____ ICD-Dx #3: _____ ICD-Dx Other: _____

Copay: \$ _____ New Patient: Yes No

Authorization Required: Yes No #Sessions Auth'd _____ Start _____ End _____ Auth. # _____

Provider: 101177 - Andersen

Special Instructions: