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 informaton 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: