

PLEASE PRINT

CONFIDENTIAL CLIENT INFORMATION

Date: _____

Name: _____ Date of Birth: _____

Mailing Address: _____
First Middle Initial Last

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 **Andrew Donohue, D.O.** 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: 101149 - Donohue

Special Instructions: