FAMILY HEALTH SERVICES
INITIAL INFORMATION

Today's Date: _____

Name: _____ _____ _____BirthDate _____

Address:_____ _____

City/State: _____ Zipcode: _____

Home Phone:_____ Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer: _____

Name of Spouse or Parent: _____ BirthDate: _____

Employer:_____ Work Phone: _____

Referred by: _____Phone #: _____

Primary Care MD: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Insurance Information

Primary Beneficiary: _____Policy Holder:_____ _____

Primary Insurance Co: _____

Address: _____

_____

ID # _____ Policy #: _____Group #:_____

Authorization #: _____

Contact Person: _____Phone #: _____

Have you contacted insurance to verify coverage and arrange for any procedures they require?
Yes _____ Not Yet _____

Payment Plan: Insurance Co-Pay Amount:
Self-Pay Self-Pay Amoiunt:

DSMIV Diagnosis: _____ CPT Codes:_____

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