Name (last, first): ____________________ , ______________________ DOB: ______________________

Address: ________________________________ City: _______________ State: ________ Zip: _____________

SS#: _________ - _____ - _________ Marital Status: ______________ Gender: ___ Female ___ Male

Phone - Home: ____________________ Work: ____________________ Cell: ____________________

E-mail Address: _______________________________________ @ __________________________________

Employer: _________________________________ Occupation: ______________________ Yrs. Employed: _____

Referring Physician: ____ Phone: _____________________________

Address: ____

Primary Care Physician: ____ Phone: _____________________________

Address: ____

Therapist / Counselor: ____ Phone: _____________________________

Address: ____

EMERGENCY CONTACT

Name: ____ Relationship: _____________________

Home Phone: ________________________ Work: ________________________ Cell: ________________________

INSURANCE INFORMATION ***(all blanks must be filled in)*** **Please provide insurance card(s) on day of visit.**

[ ] SELF - PAY [ ] WORKER'S COMP [ ] INSURANCE

Primary INS Name: ____ Policy Holder: __________________________

ID: ____ **Group:** _________________________________

SS# of policy holder: _________ - _____ - _________ **DOB of Policy Holder:** _________________

Employer of Policy Holder: ________________________ **Relationship to Patient:** _________________

Secondary INS Name: _____________________________________ **Policy Holder:** ___________________________

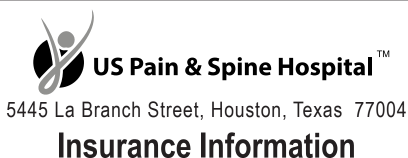
ID: ____ **Group:** _________________________________

SS# of policy holder: _________ - _____ - _________ **DOB of Policy Holder:** _________________

Employer of Policy Holder: ________________________ **Relationship to Patient:** _________________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

Signature of Patient / Responsible Party: ____ Date: ________________



5445 La Branch Street, Houston, Texas 77004

Insurance Information

PC 005 (02/17)