PATIENT INFORMATION

Please complete all fields and provide us with a copy of your photo identification and insurance card(s) as applicable.

Last Name:____________________ First Name: ________________ MI: __________

Home Address: ____________________ City: ____________________

State: ________ Zip Code: ________ Sex/Identify AS: M F Other:____________

DOB________ Race/Ethnicity:____________ Employer: ________________

Home Phone:________________ Work Phone________________ Ext______

Cell Phone:________________ Okay to leave a message? Yes No

SS # ________________ Name you would like us to call you:________________

Email: ________________Marital Status S M D W Other____________

Family Physician________________ How did you hear about us? ________________

Financially Responsible Party (if other than patient):________________________

Pharmacy Name:____________________ Pharmacy Location: ________________

INSURANCE INFORMATION:

Insurance:________________________ Is this your primary insurance? YES NO

Insurance ID#________________________ Group or plan #________________

Subscriber Name: ____________________ Relationship to patient: ________________

Subscriber SS#________________________ DOB____________________

Is insurance through your employer? YES NO Insured's Employer____________________

Do you have a secondary Insurance? YES NO Name of plan____________________

Insurance ID#________________________ Group or Plan #________________

Insured's Name: ____________________ Insured's DOB:____________________

In case of Emergency Notify________________________ **Phone**________________

Relationship to Patient:____________________________________

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. UPON ANY CHANGE IN MY INFORMATION, I WILL IMMEDIATELY PROVIDE UPDATES TO THIS OFFICE. I UNDERSTAND THAT ALTHOUGH I HAVE INSURANCE, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO THIS OFFICE AND AGREE TO PAY ALL BALANCES DUE. I AUTHORIZE STERLING CARE PSYCHIATRIC GROUP TO RELEASE ALL INFORMATION NECESSARY FOR MY INSURANCE TO PAY OR CONSIDER MY CLAIMS.

Patient Signature:____Date:__________________

Parent/Guardian Signature:__________________________________ Date:_________________
(If patient is a minor)