

Biofeedback and Family Therapy Center · Steven C. Kassel, MFT, BCB, BCN, AAPM 23560 Lyons Av., #204, Newhall, CA 91321 1545 Sawtelle Blvd, #25, Los Angeles, CA 90025 661 259-3704 fax 661 254-8574 S@kassel.us

PATIENT INFORMATION

Date of First Visit	Date of Injury/Onset:	
Patient's Name:	Gender: Male/Female	Date of Birth:
Social Security #:	Marital Status: S M	D W DL#:
Address:		Apt #:
City:	State:	Zip:
Home Phone #:	Work Phone #:	Email Address
Employer Name:		
Employer Address:	City:	State: Zip:
Primary Physician:	Phone #:	
Date of last MD Visit:	Diagnosis:	
Prescription Frequency & Duration:		
Referred By:	Phone #:	
Address:		
City, State, Zip:		
In case of emergency:	Phone #:	
PRIMARY INSURANCE INFORMATION (no need to fill out if you have given a copy of your card(s))		
Insurance Carrier:	Phone #:	
Insured Name:	ID #:	
Insured Date of Birth:	Group #:	Policy #:
Adjustor Name:	Phone #:	
Claim #:	#: Authorization #:	
SECONDARY INSURANCE INFORMATION		
Insurance Carrier:	Phone #: _	
Insured Name:	ID #:	
Insured Date of Birth:	Group #:	Policy #:
Adjustor Name:	Phone #:	