Biofeedback and Family Therapy Center
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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, City, State Zip: _____:_____

Home/cell Phone #:_____ Work Phone #:_____ Email Address:_____

Employer Name: _____ Employee 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#/Ext #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Group #: _____ Policy #:_____

Adjustor Name: _____ Phone #: _____Claim #: _____ Authorization #: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____ Adjuster Name: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Group #: _____ Policy #:_____