

THE CENTER FOR BEHAVIORAL HEALTH

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Patient Information

Patients Name: _____ Date of Birth: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Name of Spouse (or Parent): _____

Social Security Number of Insurance Policy Holder: _____

Insurance Carrier: _____ Insurance ID#: _____

Referral Source: _____ Family Physician: _____

I have read and understood the Office Policy sheet attached. In addition I give permission to my therapist and the Center for Behavioral Health to exchange information with my physician.

Print Name

Signature

Date