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Client Information Sheet

Schwartz Therapy + Wellness, P.C.
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Please Print Clearly

Client Full Name: ____

Date of Birth: ______________ Gender: M F Phone #: _________________

Relationship of Insured: SELF _____ SPOUSE ______ DEPENDENT ________

Address: ____

City: _______________________ State: ___________ Zip: _______

E-mail: ____

Emergency Contact/ Relationship: ____________________________________

Phone: __________________ E-mail: ________________________________

INSURANCE CARRIER INFORMATION

Name of Primary Insurance Carrier: ____________________________________

Insured Name (subscriber/employee): ___________________________________

Insured's ID# (front of card): ________________________Group #: _______________

Insured's Address: ____

City, State, Zip: ____

Card Holder's Date of Birth: ___________________________ Phone #: ___________

SECONDARY CARRIER INFORMATION

Name of Secondary Insurance Carrier: __________________________________

Insured Name (subscriber/employee): ___________________________________

Insured's ID# (front of card): ________________________Group #: _______________

Insured's Address: ____

City, State, Zip: ____

Card Holder's Date of Birth: ___________________________ Phone #: ___________

PLEASE INCLUDE A COPY OF THE INSURANCE CARD(S) FRONT + BACK

I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government or private benefits to my provider who accepts assignment of benefits on this claim(s).

X ____ _______________

Signature of Financially Responsible Party Date