MONARCH BEHAVIORAL HEALTH ASSOCIATES

PATIENT INFORMATION FORM

(TO BE COMPLETED BY PATIENT)

PATIENT INFORMATION: {RELATIONSHIP TO SUBSCRIBER_____}

Name:_____**Address:**_____

City:_____ **Zip Code:**_____ **Home Phone:**_____ **Work Phone:**_____

Cell Phone:_____ **SS Number:**_____ **DOB:**_____

Employer:_____ **Marital Status**_____

Permission to call? YES ☐ NO ☐ Permission to leave message? YES ☐ NO ☐

SUBSCRIBER INFORMATION: *{IF SAME AS PATIENT, CHECK HERE ☐ }*

Name:_____**Address:**_____

City:_____ **Zip Code:**_____ **Home Phone:**_____ **Work Phone:**_____

Cell Phone:_____ **SS Number:**_____ **DOB:**_____

Employer:_____ **Marital Status**_____

_____

Name of Health Insurance Company:_____

Address and telephone number on back of card:_____

_____

Member ID #:_____

Group #:_____

Secondary Insurance (if applicable):_____

Member ID#:_____

I certify that the above information is accurate and current, and I give consent for Monarch Behavioral Health Associates to share this information with my health insurance company for the purposes of billing for services provided

CLIENT OR GUARDIAN SIGNATURE:_____**DATE:**_____

Clinician:_____ **DSM code:**_____
(please print name)