Patient Name____
(Last) (First) (MI)

Address______________________City______________State__________Zip__________

Phone #__________________Sex____Date of Birth____________ Patient SSN______________

Primary Care Physician______________________________Phone #__________________

Referred By______________________________Phone #__________________

Parent's Name______________________________Parent Date of Birth__________________

Home Phone #______________Cell Phone #____________Parent SSN__________________

Email____

Parent Employer______________________________Employer Phone #__________________

Spouse Name______________________________Spouse Date of Birth__________________

Home Phone #______________Cell Phone #____________Spouse SSN__________________

Email____

Spouse Employer______________________________Employer Phone #__________________

Emergency Contact______________________________Relationship__________________

Address______________________________Phone #__________________

PRIMARY INSURANCE INFORMATION (all fields are Required)

Insurance Company______________________________Phone #__________________

ID #______________________________Group #__________________

Cardholder's Name______________________________Relationship to Patient__________________

SECONDARY INSURANCE INFORMATION (all fields are Required)

Insurance Company______________________________Phone #__________________

ID #______________________________Group #__________________

Cardholder's Name______________________________Relationship to Patient__________________

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO: STONES WORTH STEPPING, P.C.
I acknowledge that it is my responsibility to know my insurance benefits for occupational, physical and speech therapy services. I assume responsibility for payments denied by my insurance company.

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(Signature)