Mindful Balance Psychiatry

Patient Coverage Information Form

Welcome to Mindful Balance Psychiatry Center. In order to serve you more effectively please complete the following information. **PLEASE PRINT CLEARLY!**

Part 1: Patient Information

Patient's Name: _____ DOB _____

Home Address: _____ Hm Ph # _____

Cell Ph # _____ City: _____ State: _____ Zip: _____

Gender: _____ Martial Status: S M D W Other SS# _____

Email: _____

Place of Employment: _____ Drc Lic # _____

Employer's Address: _____ Work # _____

Part 2: Name of Insurance Holder - Skip this section if you brought in the card for us to make a copy

Insured's Name: _____ SS # _____

Insured's Employer: _____ Wk # _____

Employer's Address: _____ City: _____

Occupation: _____ State: _____ Zip: _____

Relationship to Patient: Self Spouse Dependent Other: _____

Part 3: Responsible Party (Statements will be sent to)

Name: _____ Hm Ph # _____

Address: _____ Wk Ph # _____

City: _____ State: _____ Zip: _____

Relationship to Patient: Self Spouse Dependent Other: _____

(OVER)