



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 #: \_\_\_\_\_

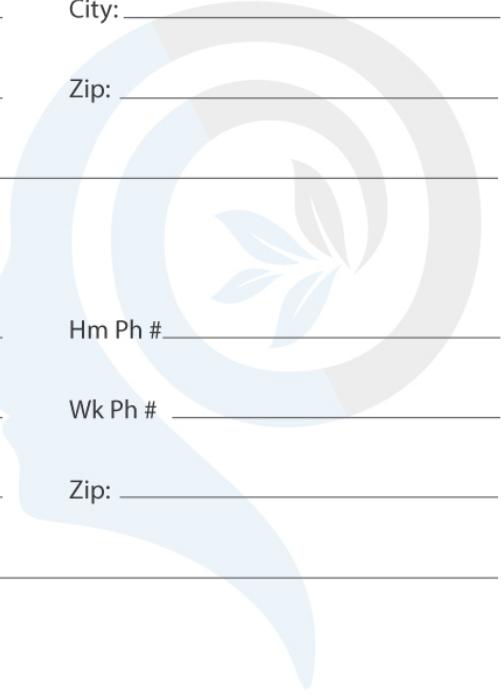
Employer's Address: \_\_\_\_\_

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)**